

Global COVID-19 Clinical Platform

RAPID CORE CASE REPORT FORM (CRF)

INTRODUCTION

In response to the COVID-19 pandemic, the World Health Organization (WHO) has launched a global COVID-19 anonymized clinical data platform (the “COVID-19 Data Platform”) to enable State Parties to the International Health Regulations (IHR) (2005) to share with WHO anonymized clinical data related to patients with suspected or confirmed infections with SARS-CoV-2 (collectively “anonymized COVID-19 data”). The anonymized COVID-19 data received by WHO will remain the property of the contributing Entity and will be used by WHO for purposes of verification, assessment and assistance pursuant to the IHR (2005), including to inform the public health and clinical operation response in connection with the COVID-19 outbreak. To help achieve these objectives, WHO has established an independent Clinical Advisory Group to advise WHO on global reporting and analysis of the anonymized clinical COVID-19 data. State Parties and other entities are invited to contact WHO to obtain more information about how to contribute anonymized clinical COVID-19 data to the WHO Data Platform. To preserve the security and confidentiality of the anonymized COVID-19 data, State Parties and other entities are respectfully requested to take all necessary measures to protect their respective log-in credentials and passwords to the COVID-19 Data Platform.

The anonymized COVID-19 data will be stored in the WHO COVID-19 Data Platform, which is a secured, access-limited, password protected electronic platform. WHO will (i) protect the confidentiality and prevent the unauthorized disclosure of the anonymized COVID-19 data; (ii) implement and maintain appropriate technical and organizational security measures to protect the security of the anonymized COVID-19 data and the COVID-19 Data Platform. In accordance with Article 11(4) of the IHR (2005), WHO will not make the anonymized COVID-19 data generally available to other State Parties or entities until such time as any of the conditions set forth in paragraph 2 of Article 11 are first met, and following consultation with affected countries/entities. Pursuant to that same Article 11, WHO will not make the anonymized COVID-19 data available to the public, unless and until the anonymized COVID-19 data have already been made available to State Parties, and provided that other information about the COVID-19 epidemic has already become publicly available and there is a need for the dissemination of authoritative and independent information. To contribute data to the WHO COVID-19 Data Platform or to receive more information, please contact:

COVID_ClinPlatform@who.int

DESIGN OF THIS CASE REPORT FORM (CRF)

The Rapid Core CRF is designed to collect data obtained through examination, interview and review of hospital notes. Data may be collected prospectively or retrospectively. The data collection period is defined as the period from hospital admission to discharge, transfer, death, or continued hospitalization without possibility of continued data collection.

This CRF has 3 modules:

- Module 1:** to be completed on the first day of admission to the health centre.
- Module 2:** to be completed daily during hospital stay for as many days as resources allow. Continue to follow-up patients who transfer between wards.
- Module 3:** to be completed at discharge or death.

GENERAL GUIDANCE

- Participant identification numbers consist of a site code and a participant number. You can register on the data management system by contacting COVID_ClinPlatform@who.int, and our data management team will contact you with instructions for data entry and will assign you a 5-digit site code at that time.
- Please contact us at COVID_ClinPlatform@who.int for any information.

MODULE 1. Complete on hospital admission (within 24 hrs from hospital admission)

Facility name

Country

Date of enrolment [D][/][M][/][2][0][Y][Y]

1a. CLINICAL INCLUSION CRITERIA

One or more of these during this illness	A history of self-reported feverishness or measured fever of $\geq 38^{\circ}\text{C}$	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dyspnoea (shortness of breath) OR Tachypnoea*	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Clinical suspicion despite not meeting criteria above	<input type="checkbox"/> Yes <input type="checkbox"/> No

* Respiratory rate ≥ 50 breaths/min for < 1 year; ≥ 40 for 1–4 years; ≥ 30 for 5–12 years; ≥ 20 for ≥ 13 years

1b. DEMOGRAPHICS

Sex at birth ☐Male ☐Female ☐Not specified **Date of birth** [D][/][D][/][M][/][M][/][Y][/][Y][/][Y][/][Y]

If date of birth is unknown, record: **Age** [||] **years** OR [||] **months** OR [||] **days**

Health care worker? ☐Yes ☐No ☐Unknown **Laboratory worker?** ☐Yes ☐No ☐Unknown

Pregnant?* ☐Yes ☐No ☐Unknown ☐N/A **If yes: Gestational weeks assessment** [] weeks

If currently pregnant or recently pregnant (delivery within 21 days of symptom onset), complete Pregnancy CRF

1c. DATE OF ONSET AND ADMISSION VITAL SIGNS (first available data at presentation/admission)

Symptom onset (date of first/earliest symptom) [D || D || M || M || 2 || 0 || Y || Y]

Admission date at this facility [D][D][M][M][2][0][Y][Y]

Temperature [°C] Heart rate [beats/min]

Respiratory rate [] breaths/min

BP [][][](systolic) [][][](diastolic)mmHg **Severe dehydration** ☐Yes ☐No ☐Unknown

Sternal capillary refill time > 2 seconds ☐Yes ☐No ☐Unknown

Oxygen saturation: [] [] % on ☐ Room air ☐ Oxygen therapy ☐ Unknown **A V P U** (circle one)

Glasgow Coma Score (GCS/15) [] **Malnutrition** ☐Yes ☐No ☐Unknown

Mid-upper arm circumference [] [] [] mm **Height** [] [] [] cm **Weight** [] [] [] kg

1d. CO-MORBIDITIES (existing at admission) (Unk = Unknown)

Chronic cardiac disease (not hypertension)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
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Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Current smoking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
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Chronic pulmonary disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Tuberculosis (<i>active</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
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Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Tuberculosis (<i>previous</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
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Chronic kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Asplenia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
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Chronic liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Malignant neoplasm	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
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Chronic neurological disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
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If yes, specify: _____

HIV	<input type="checkbox"/> Yes (on ART)	<input type="checkbox"/> Yes (not on ART)	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	ART regimen
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1e. PRE-ADMISSION AND CHRONIC MEDICATION Were any of the following taken within 14 days of admission

Angiotensin converting enzyme inhibitors (ACE inhibitors)? ☐Yes ☐No ☐Unknown

Angiotensin II receptor blockers (ARBs)? ☐Yes ☐No ☐Unknown

Non-steroidal anti-inflammatory (NSAID)? ☐Yes ☐No ☐Unknown

Antiviral? ☐ Chloroquine/hydroxychloroquine ☐ Azithromycin ☐ Lopinavir/Ritonavir ☐ Other:

1f. SIGNS AND SYMPTOMS ON ADMISSION (Unk = Unknown)			
History of fever	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Lower chest indrawing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
with sputum production	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Altered consciousness/confusion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
with haemoptysis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Runny nose	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Vomiting/nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Diarrhoea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Conjunctivitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Muscle aches	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Skin rash	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Joint pain (arthralgia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Skin ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Fatigue/malaise	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Lymphadenopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Loss of taste	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Inability to walk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Loss of smell	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If bleeding, specify site(s):	
Stroke: ischaemic stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Stroke: intracerebral haemorrhage	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
If yes, specify:			

1g. MEDICATION On the day of admission, did the patient receive any of the following:	
Oral/orogastric fluids? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Intravenous fluids? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Antiviral? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes: <input type="checkbox"/> Ribavirin <input type="checkbox"/> Lopinavir/Ritonavir <input type="checkbox"/> Neuraminidase inhibitor
<input type="checkbox"/> Interferon alpha <input type="checkbox"/> Interferon beta <input type="checkbox"/> Other, specify: _____	
Corticosteroid? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, route: <input type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Inhaled
If yes, please provide agent and maximum daily dose: _____	
Antibiotic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, specify: _____
Antifungal agent? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Antimalarial agent? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, specify: _____
Experimental agent? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, specify: _____
Non-steroidal anti-inflammatory (NSAID) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Angiotensin converting enzyme inhibitors (ACE inhibitors) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Angiotensin II receptor blockers (ARBs) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Systemic anticoagulation <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

1h. SUPPORTIVE CARE On the day of admission, did the patient receive any of the following:	
ICU or high dependency unit admission? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Oxygen therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, complete all below
O ₂ flow: <input type="checkbox"/> 1–5 L/min <input type="checkbox"/> 6–10 L/min <input type="checkbox"/> 11–15 L/min <input type="checkbox"/> > 15 L/min <input type="checkbox"/> Unknown	
Source of oxygen: <input type="checkbox"/> Piped <input type="checkbox"/> Cylinder <input type="checkbox"/> Concentrator <input type="checkbox"/> Unknown	
Interface: <input type="checkbox"/> Nasal prongs <input type="checkbox"/> HF nasal cannula <input type="checkbox"/> Mask <input type="checkbox"/> Mask with reservoir <input type="checkbox"/> CPAP/NIV mask <input type="checkbox"/> Unknown	
Non-invasive ventilation? (e.g. BIPAP/CPAP) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Invasive ventilation (any)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If yes, what were the following values closest to 08:00:	
PEEP (cm H ₂ O) _____; FiO ₂ (%) _____; Plateau pressure (cm H ₂ O) _____; PaCO ₂ _____; PaO ₂ _____	
Extracorporeal (ECMO) support? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Prone position? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Inotropes/vasopressors? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

1i. LABORATORY RESULTS ON ADMISSION (*record units if different from those listed)								
Parameter	Value*	Units			Parameter	Value*	Units	
Haemoglobin		<input type="text"/> g/L	<input type="text"/> g/dL		Creatinine		<input type="text"/> mg/L	<input type="text"/> μmol/L
WBC count		<input type="text"/> /mm ³	<input type="text"/> G/L (= x10 ⁹ /L)		Sodium		<input type="text"/> mEq/L = mmol/L	
Haematocrit		<input type="text"/> %			Potassium		<input type="text"/> mEq/L = mmol/L	
Platelets		<input type="text"/> /mm ³	<input type="text"/> G/L (= x10 ⁹ /L)		Procalcitonin		<input type="text"/> ng/mL	<input type="text"/> μg/L
APTT/APTR		<input type="text"/> seconds			CRP		<input type="text"/> mg/L	
PT (seconds)		<input type="text"/> seconds			LDH		<input type="text"/> IU/L	
INR					Creatine kinase		<input type="text"/> IU/L	<input type="text"/> UKAT/L
ALT/SGPT		<input type="text"/> IU/L			Troponin		<input type="text"/> ng/mL	<input type="text"/> μg/L
AST/SGOT		<input type="text"/> IU/L			ESR		<input type="text"/> mm/hour	
Total bilirubin		<input type="text"/> mg/L	<input type="text"/> μmol/L		D-dimer		<input type="text"/> ng/mL	<input type="text"/> μg/L
Urea (BUN)		<input type="text"/> g/L	<input type="text"/> mg/dL	<input type="text"/> mmol/L	Ferritin		<input type="text"/> ng/mL	<input type="text"/> μg/L
Lactate		<input type="text"/> mg/dL	<input type="text"/> mmol/L		IL-6		<input type="text"/> pg/mL	

MODULE 2. Daily follow up during hospital stay (daily or as frequent as possible based on feasibility)

Date of follow up | _ | _ | / | _ | _ | / | 2 | 0 | | _ | _ |

2a. VITAL SIGNS (record most abnormal value between 00:00 to 24:00)

Temperature | _ | _ | . | _ | °C **Heart rate** | _ | _ | beats per min **Respiratory rate** | _ | _ | breaths/min
BP | _ | _ | (systolic) | _ | _ | (diastolic) mmHg **Severe dehydration** ☐ Yes ☐ No ☐ Unknown
Sternal capillary refill time > 2 seconds ☐ Yes ☐ No ☐ Unknown **A V P U** (circle one)
Oxygen saturation on ☐ Room air ☐ Oxygen therapy ☐ Unknown **GCS/15** | _ | _ |

2b. DAILY CLINICAL FEATURES (Unk = Unknown)

Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Confusion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
and sputum production	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Vomiting/nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Diarrhoea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Conjunctivitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Loss of smell	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Myalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Loss of taste	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Other, specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

2c. LABORATORY RESULTS (*record units if different from those listed)

Parameter	Value*	Units		Parameter	Value*	Units	
Haemoglobin		__ g/L	__ g/dL	Creatinine		__ mg/L	__ µmol/L
WBC count		__ /mm ³	__ G/L (= x10 ⁹ /L)	Sodium		__ mEq/L = mmol/L	
Haematocrit		__ %		Potassium		__ mEq/L = mmol/L	
Platelets		__ /mm ³	__ G/L (= x10 ⁹ /L)	Procalcitonin		__ ng/mL	__ µg/L
APTT/APTR		__ seconds		CRP		__ mg/L	
PT (seconds)		__ seconds		LDH		__ IU/L	
INR				Creatine kinase		__ IU/L	__ UKAT/L
ALT/SGPT		__ IU/L		Troponin		__ ng/mL	__ µg/L
AST/SGOT		__ IU/L		ESR		__ mm/hour	
Total bilirubin		__ mg/L	__ µmol/L	D-dimer		__ ng/mL	__ µg/L
Urea (BUN)		__ g/L	__ mg/dL	Ferritin		__ ng/mL	__ µg/L
Lactate		__ mg/dL	__ mmol/L	IL-6		__ pg/mL	

2d. MEDICATION At any time during this 24-hour hospital day, did the patient receive:

Oral/orogastric fluids? ☐Yes ☐No ☐Unknown **Intravenous fluids?** ☐Yes ☐No ☐Unknown

Antiviral? ☐Yes ☐No ☐Unknown **If yes:** ☐Ribavirin ☐Lopinavir/Ritonavir ☐Neuraminidase inhibitor
☐Interferon alpha ☐Interferon beta ☐Other, specify: _____

Corticosteroid? ☐Yes ☐No ☐Unknown **If yes, route:** ☐Oral ☐Intravenous ☐Inhaled
If yes, please provide agent and maximum daily dose: _____

Antibiotic? ☐Yes ☐No ☐Unknown **If yes, specify:**_____

Antifungal agent? ☐Yes ☐No ☐Unknown

Antimalarial agent? ☐Yes ☐No ☐Unknown **If yes, specify:** _____

Experimental agent? ☐Yes ☐No ☐Unknown **If yes, specify:**_____

Non-steroidal anti-inflammatory (NSAID) ☐Yes ☐No ☐Unknown

Angiotensin converting enzyme inhibitors (ACE inhibitors) ☐Yes ☐No ☐Unknown

Angiotensin II receptor blockers (ARBs) ☐Yes ☐No ☐Unknown

Systemic anticoagulation ☐Yes ☐No ☐Unknown

2e. SUPPORTIVE CARE At any time during this 24-hour hospital day, did the patient receive:

ICU or high dependency unit admission? ☐ Yes ☐ No ☐ Unknown

Date of ICU/HDU admission [D][D]/[M][M]/[2][0][Y][Y] ☐ Unknown

ICU/HDU discharge date [D][D]/[M][M]/[2][0][Y][Y] ☐ Not discharged yet ☐ Unknown

Oxygen therapy? ☐ Yes ☐ No ☐ Unknown **If yes, complete all below:**

O₂ flow: ☐ 1–5 L/min ☐ 6–10 L/min ☐ 11–15 L/min ☐ > 15 L/min ☐ Unknown

Source of oxygen: ☐ Piped ☐ Cylinder ☐ Concentrator ☐ Unknown

Interface: ☐ Nasal prongs ☐ HF nasal cannula ☐ Mask ☐ Mask with reservoir ☐ CPAP/NIV mask ☐ Unknown

Non-invasive ventilation? (e.g. BIPAP, CPAP) ☐ Yes ☐ No ☐ Unknown

Invasive ventilation (any)? ☐ Yes ☐ No ☐ Unknown

If yes, what were the following values closest to 08:00:

PEEP (cm H₂O) _____; FiO₂ (%) _____; Plateau pressure (cm H₂O) _____; PaCO₂ _____; PaO₂ _____

Extracorporeal (ECMO) support? ☐ Yes ☐ No ☐ Unknown

Prone position? ☐ Yes ☐ No ☐ Unknown

Inotropes/vasopressors? ☐ Yes ☐ No ☐ Unknown

Renal replacement therapy (RRT) or dialysis? ☐ Yes ☐ No ☐ Unknown

MODULE 3. Complete at discharge/death

3a. DIAGNOSTIC/PATHOGEN TESTING

Chest X-ray/CT performed? ☐ Yes ☐ No ☐ Unknown **If yes, infiltrates present?** ☐ Yes ☐ No ☐ Unknown

Was pathogen testing done during this illness episode? ☐ Yes ☐ No ☐ Unknown **If yes, complete all below:**

Influenza virus: ☐ Positive ☐ Negative ☐ Not done **If positive, type** _____

Coronavirus: ☐ Positive ☐ Negative ☐ Not done **If positive:** ☐ MERS-CoV ☐ SARS-CoV-2 ☐ Other _____

Other respiratory pathogen: ☐ Positive ☐ Negative ☐ Not done **If positive, specify** _____

Viral haemorrhagic fever: ☐ Positive ☐ Negative ☐ Not done **If positive, specify virus** _____

Other pathogen of public health interest detected: **If yes, specify:** _____

Falciparum malaria: ☐ Positive ☐ Negative ☐ Not done

Non-falciparum malaria: ☐ Positive ☐ Negative ☐ Not done

HIV: ☐ Positive ☐ Negative ☐ Not done

3b. COMPLICATIONS At any time during hospitalization, did the patient experience:

Shock	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Bacteraemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Seizure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Meningitis/encephalitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Endocarditis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Anaemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Myocarditis/pericarditis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cardiac arrhythmia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Acute renal injury	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cardiac arrest	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Pancreatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Liver dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Bronchiolitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Cardiomyopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Acute respiratory distress syndrome (ARDS)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other If yes, specify	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Stroke: ischaemic stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Stroke: intracerebral haemorrhage	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

3c. MEDICATION While hospitalized or at discharge, were any of the following administered:

Oral/orogastric fluids? ☐ Yes ☐ No ☐ Unknown **Intravenous fluids?** ☐ Yes ☐ No ☐ Unknown

Antiviral? ☐ Yes ☐ No ☐ Unknown **If yes:** ☐ Ribavirin ☐ Lopinavir/Ritonavir ☐ Neuraminidase inhibitor
☐ Interferon alpha ☐ Interferon beta ☐ Other, specify: _____

Corticosteroid? ☐ Yes ☐ No ☐ Unknown **If yes, route:** ☐ Oral ☐ Intravenous ☐ Inhaled
If yes, specify agent and maximum daily dose: _____

Antibiotic? ☐ Yes ☐ No ☐ Unknown **If yes, specify:** _____

Antifungal agent? ☐ Yes ☐ No ☐ Unknown **If yes, specify:** _____

Antimalarial agent? ☐ Yes ☐ No ☐ Unknown **If yes, specify:** _____

Experimental agent? ☐ Yes ☐ No ☐ Unknown **If yes, specify:** _____

Non-steroidal anti-inflammatory (NSAID) ☐ Yes ☐ No ☐ Unknown **If yes, specify:** _____

Systemic anticoagulation ☐ Yes ☐ No ☐ Unknown

3d. SUPPORTIVE CARE At any time during hospitalization, did the patient receive/undergo:

ICU or high dependency unit admission? ☐ Yes ☐ No ☐ Unknown If yes, total duration: _____ days

Date of ICU admission [D][D][M][M][2][0][Y][Y] ☐ N/A

Date of ICU discharge [D | | D | | M | | M | | 2 | | 0 | | Y | | Y] ☐ In ICU at outcome ☐ N/A

Oxygen therapy? ☐Yes ☐No ☐Unknown **If yes**, complete all: Total duration:_____days

O₂ flow: ☐ 1–5 L/min ☐ 6–10 L/min ☐ 11–15 L/min ☐ > 15 L/min

Source of oxygen: ☐Piped ☐Cylinder ☐Concentrator

Interface: ☐ Nasal prongs ☐ HF nasal cannula ☐ Mask ☐ Mask with reservoir ☐ CPAP/NIV mask

Non-invasive ventilation? (e.g. BIPAP, CPAP) ☐Yes ☐No ☐Unknown **If yes**, total duration: _____ days

Invasive ventilation (any)? ☐Yes ☐No ☐Unknown **If yes**, total duration:_____ days

Extracorporeal (ECMO) support? ☐Yes ☐No ☐Unknown **If yes, total duration:** _____ days

Prone position? ☐Yes ☐No ☐Unknown **If yes, total duration:**_____ days

Inotropes/vasopressors? ☐Yes ☐No ☐Unknown **If yes**, total duration: _____ days

Renal replacement therapy (RRT) or dialysis? ☐Yes ☐No ☐Unknown

3e. OUTCOME

Outcome: ☐ Discharged alive ☐ Hospitalized ☐ Transfer to other facility ☐ Death ☐ Palliative discharge ☐ Unknown

Outcome date: [D][D]/[M][M]/[2][0][Y][Y] ☐Unknown

If discharged alive, ability to self-care at discharge versus before illness: ☐ Same as before illness ☐ Worse
☐ Better ☐ Unknown