Screening form

Please complete the form below to determine your eligibility to fill out the survey.

Thank you!

If you would like to try out the survey without entering actual data, please visit our test survey.

Do you intend to make a report on a patient who has a presumptive or lab-proven diagnosis of COVID-19 and has a current or past medical history of an invasive malignancy?

◯ Yes
◯ No

We're sorry, but this survey is is intended to report on patients with COVID-19 and cancer. Non-melanoma skin cancer, in situ cancers, and premalignant conditions are excluded.

Please click the button to exit the survey.

◯ Exit the survey

Have you previously reported this patient to this or any other registry?

◯ No
◯ This registry
◯ Another registry

If you have additional follow-up information to add to an existing report, you should return to that report and update the content.

Please feel free to fill out the survey. In order to help us avoid duplication with other complementary efforts, please optionally list the names of the other registries that you have reported to.

_____

Are you reporting on behalf on an institution participating in the CCC19 consortium?

◯ Yes
◯ No

We're sorry, but this survey is currently open only to respondents who are at a CCC19 participating institution. The attached FAQ provides some details about getting involved as a participating institution.

If you would like your site to get involved, please contact us through the CCC19 website.

[Attachment: "FAQ for potential participants.pdf"]

Please click the button below to exit the survey.

◯ Exit the survey

Please identify the participating institution.

- ◯ Albert Einstein Cancer Center
- ◯ Aurora Health Care
- ◯ Baptist Cancer Center (Memphis, TN)
- ◯ Baptist Healthcare System (IN/KY)
- ◯ Barrow Neurological Institute
- ◯ Baylor College of Medicine
- ◯ BC Cancer
- ◯ Beth Israel Deaconess Medical Center (BIDMC)
- ◯ Boston Medical Center
- ◯ Brown University
- ◯ Cancer Treatment Centers of America (CTCA)
- ◯ Centre Hospitalier de l'Université de Montréal (CHUM)
- ◯ Centro Médico ABC
- ◯ City of Hope
- ◯ Cleveland Clinic
- ◯ Columbia University/New York Presbyterian
- ◯ Cook County Hospital
- ◯ Dana-Farber Cancer Institute (DFCI)
- ◯ Duke University
- ◯ Einstein Medical Center
- ◯ Emory University/Winship Cancer Institute
- ◯ Fred Hutchinson Cancer Research Center/University of Washington/Seattle Cancer Care Alliance
- ◯ Geisinger Health System
- ◯ Georgetown Lombardi Comprehensive Cancer Center at Georgetown University
- ◯ George Washington University
- ◯ Gundersen Health System
- ◯ Hamilton Health Sciences
- ◯ Harold C. Simmons Comprehensive Cancer Center at the University of Texas Southwestern Medical Center
- ◯ Hartford HealthCare Cancer Institute
- ◯ HCA Houston Healthcare
- ◯ Henry Ford Cancer Institute
- ◯ Hôpital Pierre-Le Gardeur
- ◯ Hospital General de México
- ◯ Hospital Regional de Alta Especialidad de Ixtalapuca
- ◯ Houston Methodist Cancer Center
- ◯ Huntsman Cancer Institute
- ◯ Inova Schar Cancer Institute
- ◯ Instituto Nacional de Cancerología
- ◯ Intermountain Healthcare
- ◯ Johns Hopkins University
- ◯ Kaiser Permanente Northwest
- ◯ Karmanos Cancer Institute
- ◯ Lewis Cancer & Research Pavilion @ St. Joseph's/Candler
- ◯ Loma Linda University Cancer Center
- ◯ Loyola University Medical Center
- ◯ LSU Health Sciences Center
- ◯ Markey Cancer Center at the University of Kentucky
- ◯ Massachusetts General Hospital (MGH)
- ◯ Mayo Clinic
- ◯ Mays Cancer Center at UT Health San Antonio
- ◯ McGill University Health Centre
- ◯ MD Anderson Cancer Center
- ◯ Medical University of South Carolina/Hollings Cancer Center
- ◯ Meharry Medical College
- ◯ Memorial Sloan-Kettering Cancer Center (MSKCC)
- ◯ Michigan Center of Medical Research
- ◯ Missouri Baptist Cancer Center
- ◯ Moffitt Cancer Center
- ◯ Mount Auburn Hospital
- ◯ Mount Carmel Health System
- ◯ Mount Sinai/Tisch Cancer Institute
- ◯ Northwell Health

◯ Northwest Medical Specialties
◯ Northwestern University/Lurie Cancer Center
◯ NYU Langone Health/Perlmutter Cancer Center
◯ O'Neal Comprehensive Cancer Center at UAB
◯ Oregon Health & Sciences University/Knight Cancer Institute (OHSU)
◯ Parkview Cancer Institute/Parkview Research Center
◯ Penn State Cancer Institute
◯ Penn State Health St. Joseph Cancer Center
◯ Roswell Park Comprehensive Cancer Center
◯ Rush University Medical Center
◯ Rutgers Cancer Institute of New Jersey
◯ Segal Cancer Centre, Jewish General Hospital, McGill University
◯ Sidney Kimmel Cancer Center at Thomas Jefferson University
◯ SSM Health Cancer Care
◯ Stamford Hospital
◯ Stanford University
◯ St. Elizabeth Healthcare
◯ Sutter Health
◯ Ohio State University Comprehensive Cancer Center
◯ Tallahassee Memorial Healthcare
◯ ThedaCare Cancer Care
◯ Thompson Cancer Survival Center
◯ Tripler Army Medical Center
◯ Tufts Medical Center
◯ UCLA Jonsson Comprehensive Cancer Center
◯ University Hospitals, Cleveland
◯ University of California, Davis
◯ University of California, San Diego (UCSD)
◯ University of California, San Francisco (UCSF)
◯ University of Chicago
◯ University of Cincinnati Cancer Center
◯ University of Colorado Cancer Center
◯ University of Connecticut
◯ University of Florida Health Cancer Center
◯ University of Hawaii Cancer Center
◯ University of Illinois at Chicago (UIC)
◯ University of Iowa Holden Comprehensive Cancer Center
◯ University of Kansas
◯ University of Louisville James Graham Brown Cancer Center
◯ University of Maryland
◯ University of Miami/Sylvester Comprehensive Cancer Center
◯ University of Michigan/Rogel Cancer Center
◯ University of Minnesota
◯ University of Mississippi Medical Center
◯ University of Nebraska Medical Center/Buffett Cancer Center
◯ University of North Carolina/Lineberger Comprehensive Cancer Center
◯ University of Rochester Medical Center
◯ University of Wisconsin Carbone Cancer Center
◯ UPMC Western Maryland
◯ Vanderbilt University Medical Center/Vanderbilt-Ingram Cancer Center
◯ Vidant Medical Center, East Carolina University
◯ Virginia Mason Cancer Institute
◯ Virtua Health
◯ Wake Forest Baptist Comprehensive Cancer Center
◯ Washington University in St. Louis/Siteman Cancer Center
◯ Weill Cornell Medicine/Meyer Cancer Center
◯ WellSpan Health
◯ Wentworth-Douglass Hospital
◯ West Cancer Center
◯ Willis-Knighton Cancer Center
◯ Yale New Haven Health/Smilow Cancer Hospital

	◯ Yuma Regional Medical Center ◯ TEST
Are you a healthcare provider or entering data on a healthcare provider's behalf?	◯ Yes ◯ No
This survey is currently open only to healthcare professionals or those entering data on behalf of a healthcare professional. If you are a patient or care partner looking to enter data about yourself or someone you know, please know we are currently working on strategies to reach out to you. If you would like to learn more about patient involvement in CCC19, check our website - we will update our website as we develop more ways for patients to get involved. Thank you for your patience! Please click the button below to exit the survey.	◯ Exit the survey
Are you based in any of the listed countries or regions?	◯ United States or the U.S. territories ◯ European Union (EU) ◯ Argentina ◯ Canada ◯ Mexico ◯ United Kingdom ◯ Germany ◯ Italy ◯ Spain ◯ No - I am not based in any of those countries or regions
We're sorry, but the IRB does not allow us to collect data from your country at this time. However, we are actively looking into adding international participation on a country-by-country basis. Please visit our website for more information; you will be redirected there once you end the survey by clicking the button.	◯ Exit the survey

Patient Demographics, Medical History, Labs

Thank you for visiting this survey, which is intended to be filled out by healthcare professionals or their proxies. The purpose of this registry is to quickly capture details related to cancer patients with presumptive or lab-confirmed COVID-19. By submitting information, you confirm that any information you provide was duly obtained in accordance with the privacy and sanitary laws that apply to you and that you have the authority to share the information with Vanderbilt University Medical Center (VUMC) for use in research activities. If you have concerns about recording non-PHI (non-identifiable) patient data here, please discuss them with your Privacy Office prior to filling out the survey.

The survey is comprised of five forms separated into mandatory and optional sections:

Patient demographics and past medical historyCOVID-19 initial course of illnessCancer detailsRespondent detailsFollow-up (repeating so that multiple time points can be captured)While many of the questions are optional, the more details that you can provide, the better. If you only fill out the mandatory questions, the survey should take less than 5 minutes to complete.

These forms are best filled out in sequence; clicking SUBMIT at the bottom of each form will take you to the next. If you do not click SUBMIT and leave the form, data will not be saved. There is a box in the top-right corner called "Survey Queue" which can be used to directly access the various forms in any order. Important: if you want to return later to add or change details, click the Survey Queue box; this will open a new window with a button that says "Get link to my survey queue". This will provide you a link back to the survey.

Please do not record any PHI in this survey, including dates! This registry is not exempted from ordinary HIPAA requirements.

In order to avoid duplicated data entry, you may want to coordinate with others at your institution so that one person is entering data on behalf of the institution.

There is no compensation for this study, which has been determined to be IRB exempt (Vanderbilt IRB #200467). If you have any questions please visit our website or contact the Principal Investigator, Dr. Jeremy Warner MD, MS (jeremy.warner@vumc.org).

Timestamp for the first form	_____
This field will only hold metadata for those sites using local REDCap instances and exporting to this database. It hold the local database record_id	_____
Please enter your local unique patient identifier here (no PHI!). If this is a test case, please enter "9999".	_____

Patient Demographics - mandatory

This section asks about patient information at the time of the COVID-19 diagnosis or during the first known encounter for COVID-19 as available for data entry.

Age at COVID-19 diagnosis (years)

- ◯ Younger than 18
- ◯ 18-29
- ◯ 30-39
- ◯ 40-49
- ◯ 50-59
- ◯ 60-69
- ◯ 70-79
- ◯ 80-89
- ◯ Older than 90
- ◯ Unknown

We have interest in collecting additional information about pediatric patients, but these more specific details would require PHI and are thus currently out of scope. You may learn more about this effort by visiting the CCC19 website (clicking this link will open a new window).

Exact age at COVID-19 diagnosis (Note: you should only enter a number between 18-89, as ages outside of this range are considered PHI) _____

Gender

- ◯ Female
- ◯ Male
- ◯ Other
- ◯ Prefer not to say

Country of patient residence

- ◯ United States of America (USA)
- ◯ ----------
- ◯ Afghanistan
- ◯ Albania
- ◯ Algeria
- ◯ American Samoa
- ◯ Andorra
- ◯ Angola
- ◯ Anguilla
- ◯ Antarctica
- ◯ Antigua and Barbuda
- ◯ Argentina
- ◯ Armenia
- ◯ Aruba
- ◯ Australia
- ◯ Austria
- ◯ Azerbaijan
- ◯ Bahamas
- ◯ Bahrain
- ◯ Bangladesh
- ◯ Barbados
- ◯ Belarus
- ◯ Belgium
- ◯ Belize
- ◯ Benin
- ◯ Bermuda
- ◯ Bhutan
- ◯ Bolivia
- ◯ Bosnia and Herzegovina
- ◯ Botswana
- ◯ Bouvet Island
- ◯ Brazil
- ◯ British Indian Ocean Territory
- ◯ Brunei Darussalam
- ◯ Bulgaria
- ◯ Burkina Faso
- ◯ Burundi
- ◯ Cambodia
- ◯ Cameroon
- ◯ Canada
- ◯ Cape Verde
- ◯ Cayman Islands
- ◯ Central African Republic
- ◯ Chad
- ◯ Chile
- ◯ China
- ◯ Christmas Island
- ◯ Cocos (Keeling Islands)
- ◯ Colombia
- ◯ Comoros
- ◯ Congo
- ◯ Cook Islands
- ◯ Costa Rica
- ◯ Cote D'Ivoire (Ivory Coast)
- ◯ Croatia (Hrvatska
- ◯ Cuba
- ◯ Cyprus
- ◯ Czech Republic
- ◯ Denmark
- ◯ Djibouti
- ◯ Dominica
- ◯ Dominican Republic
- ◯ East Timor
- ◯ Ecuador
- ◯ Egypt
- ◯ El Salvador
- ◯ Equatorial Guinea
- ◯ Eritrea
- ◯ Estonia

◯ Ethiopia
◯ Falkland Islands (Malvinas)
◯ Faroe Islands
◯ Fiji
◯ Finland
◯ France
◯ French Guiana
◯ French Polynesia
◯ French Southern Territories
◯ Gabon
◯ Gambia
◯ Georgia
◯ Germany
◯ Ghana
◯ Gibraltar
◯ Greece
◯ Greenland
◯ Grenada
◯ Guadeloupe
◯ Guam
◯ Guatemala
◯ Guinea
◯ Guinea-Bissau
◯ Guyana
◯ Haiti
◯ Heard and McDonald Islands
◯ Honduras
◯ Hong Kong
◯ Hungary
◯ Iceland
◯ India
◯ Indonesia
◯ Iran
◯ Iraq
◯ Ireland
◯ Israel
◯ Italy
◯ Jamaica
◯ Japan
◯ Jordan
◯ Kazakhstan
◯ Kenya
◯ Kiribati
◯ Korea (North)
◯ Korea (South)
◯ Kuwait
◯ Kyrgyzstan
◯ Laos
◯ Latvia
◯ Lebanon
◯ Lesotho
◯ Liberia
◯ Libya
◯ Liechtenstein
◯ Lithuania
◯ Luxembourg
◯ Macau
◯ Macedonia
◯ Madagascar
◯ Malawi
◯ Malaysia
◯ Maldives
◯ Mali
◯ Malta
◯ Marshall Islands
◯ Martinique
◯ Mauritania
◯ Mauritius
◯ Mayotte
◯ Mexico
◯ Micronesia

◯ Moldova
◯ Monaco
◯ Mongolia
◯ Montserrat
◯ Morocco
◯ Mozambique
◯ Myanmar
◯ Namibia
◯ Nauru
◯ Nepal
◯ Netherlands
◯ Netherlands Antilles
◯ New Caledonia
◯ New Zealand
◯ Nicaragua
◯ Niger
◯ Nigeria
◯ Niue
◯ Norfolk Island
◯ Northern Mariana Islands
◯ Norway
◯ Oman
◯ Pakistan
◯ Palau
◯ Panama
◯ Papua New Guinea
◯ Paraguay
◯ Peru
◯ Philippines
◯ Pitcairn
◯ Poland
◯ Portugal
◯ Puerto Rico
◯ Qatar
◯ Reunion
◯ Romania
◯ Russian Federation
◯ Rwanda
◯ Saint Kitts and Nevis
◯ Saint Lucia
◯ Saint Vincent and The Grenadines
◯ Samoa
◯ San Marino
◯ Sao Tome and Principe
◯ Saudi Arabia
◯ Senegal
◯ Seychelles
◯ Sierra Leone
◯ Singapore
◯ Slovak Republic
◯ Slovenia
◯ Solomon Islands
◯ Somalia
◯ South Africa
◯ S. Georgia and S. Sandwich Isls.
◯ Spain
◯ Sri Lanka
◯ St. Helena
◯ St. Pierre and Miquelon
◯ Sudan
◯ Suriname
◯ Svalbard and Jan Mayen Islands
◯ Swaziland
◯ Sweden
◯ Switzerland
◯ Syria
◯ Taiwan
◯ Tajikistan
◯ Tanzania
◯ Thailand
◯ Togo

◯ Tokelau
◯ Tonga
◯ Trinidad and Tobago
◯ Tunisia
◯ Turkey
◯ Turkmenistan
◯ Turks and Caicos Islands
◯ Tuvalu
◯ Uganda
◯ Ukraine
◯ United Arab Emirates
◯ United Kingdom (Britain / UK)
◯ US Minor Outlying Islands
◯ Uruguay
◯ Uzbekistan
◯ Vanuatu
◯ Vatican City State (Holy See)
◯ Venezuela
◯ Viet Nam
◯ Virgin Islands (British)
◯ Virgin Islands (US)
◯ Wallis and Futuna Islands
◯ Western Sahara
◯ Yemen
◯ Yugoslavia
◯ Zaire
◯ Zambia
◯ Zimbabwe

State or territory of patient residence

- ◯ Alabama (AL)
- ◯ Alaska (AK)
- ◯ Arizona (AZ)
- ◯ Arkansas (AR)
- ◯ California (CA)
- ◯ Colorado (CO)
- ◯ Connecticut (CT)
- ◯ Delaware (DE)
- ◯ Florida (FL)
- ◯ Georgia (GA)
- ◯ Hawaii (HI)
- ◯ Idaho (ID)
- ◯ Illinois (IL)
- ◯ Indiana (IN)
- ◯ Iowa (IA)
- ◯ Kansas (KS)
- ◯ Kentucky (KY)
- ◯ Louisiana (LA)
- ◯ Maine (ME)
- ◯ Maryland (MD)
- ◯ Massachusetts (MA)
- ◯ Michigan (MI)
- ◯ Minnesota (MN)
- ◯ Mississippi (MS)
- ◯ Missouri (MO)
- ◯ Montana (MT)
- ◯ Nebraska (NE)
- ◯ Nevada (NV)
- ◯ New Hampshire (NH)
- ◯ New Jersey (NJ)
- ◯ New Mexico (NM)
- ◯ New York (NY)
- ◯ North Carolina (NC)
- ◯ North Dakota (ND)
- ◯ Ohio (OH)
- ◯ Oklahoma (OK)
- ◯ Oregon (OR)
- ◯ Pennsylvania (PA)
- ◯ Rhode Island (RI)
- ◯ South Carolina (SC)
- ◯ South Dakota (SD)
- ◯ Tennessee (TN)
- ◯ Texas (TX)
- ◯ Utah (UT)
- ◯ Vermont (VT)
- ◯ Virginia (VA)
- ◯ Washington (WA)
- ◯ West Virginia (WV)
- ◯ Wisconsin (WI)
- ◯ Wyoming (WY)
- ◯ District of Columbia (DC)
- ◯ American Samoa (AS)
- ◯ Guam (GU)
- ◯ Northern Mariana Islands (MP)
- ◯ Puerto Rico (PR)
- ◯ U.S. Virgin Islands (VI)

What is the name of the city where the patient is receiving medical care? Optional, but will help with avoiding duplicate reports.

_____

What is the name of the healthcare facility where the patient is presenting? Optional, but will help with avoiding duplicate reports. If the facility is a satellite to a larger center, please specify in this field.	_____

Patient demographics - optional

This section asks about patient information at the time of the COVID-19 diagnosis or during the first known encounter for COVID-19 as available for data entry.

Would you like to answer additional demographic questions? This is optional but will really help us understand the granular details better.	◯ Yes ◯ No
Patient-reported race (check all that apply if patient identifies with more than one race)	☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Other ☐ Unknown / Not Reported
Patient-reported ethnicity	◯ Hispanic or Latino ◯ NOT Hispanic or Latino ◯ Unknown / Not Reported
What type of area does the patient primarily reside in?	◯ Urban (city) ◯ Suburban (town, suburbs) ◯ Rural (country) ◯ Other ◯ Unknown
What is the patient's insurance status? Check all that apply; this should be the insurance status at the time of COVID-19 diagnosis.	☐ Not insured ☐ Private insurance/managed care ☐ Medicaid ☐ Medicare ☐ Other government ☐ Unknown
Is the patient a healthcare worker?	◯ No ◯ Yes ◯ Unknown

We are currently developing a separate survey to collect more information on healthcare workers with cancer who have suspected or confirmed COVID-19. You may learn more about this effort by visiting the CCC19 website (clicking this link will open a new window).

ECOG performance status prior to infection Please record the ECOG performance status closest to the time of infection. If the patient has not had an encounter with the medical system within 3 months of the COVID-19 diagnosis, you should choose "No ECOG PS recorded within 3 months prior to COVID-19 diagnosis".	◯ 0: Fully active, able to continue with all pre-disease activities without restriction ◯ 1: Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ◯ 2: Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours ◯ 3: Capable of only limited self-care. Confined to bed or chair more than 50% of waking hours ◯ 4: Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair ◯ No ECOG PS recorded within the 3 months prior to COVID-19 diagnosis ◯ Unknown
Smoking status	◯ Current smoker ◯ Former smoker, NOS ◯ Former smoker, quit less than 1 year ago ◯ Former smoker, quit between 1 and 5 years ago ◯ Former smoker, quit between 6 and 10 years ago ◯ Former smoker, quit more than 10 years ago ◯ Never smoker ◯ Unknown
Types of inhaled smoking products. Check all that apply.	☐ Cigarettes ☐ Cigars ☐ e-Cigarettes ☐ Hookah pipe ☐ Other ☐ Unknown
Please specify type of other smoking products Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Patient height, please specify units. If you know BMI, please skip this field and enter it below. If patient has not had any recent heights taken, ok to use values up to 12 months prior to COVID-19 diagnosis.	_____
Patient weight, please specify units. If you know BMI, please skip this field and enter it below. If patient has not had any recent weights taken, ok to use values up to 3 months prior to COVID-19 diagnosis.	_____
Patient body mass index (BMI) in kg/m2 Note: please do not enter BSA here.	_____
Surgical and Medical History	
Has the patient had a surgery of any kind in the past year? This should include but not be limited to cancer surgeries.	◯ No ◯ Yes ◯ Unknown

What is the timing of the most recent surgery?

◯ Within the past month
◯ Within the past 1 to 3 months
◯ Within the past 3 to 12 months
◯ Unknown

Additional details

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Concomitant medications being taken at time of presentation with COVID-19. Check all that apply.

☐ Systemic corticosteroids ☐ Immunosuppressants ☐ Chloroquine ☐ Hydroxychloroquine (Plaquenil)
☐ Tocilizumab ☐ ACE inhibitors ☐ Angiotensin receptor blockers (ARBs) ☐ Statins
☐ Antibiotics ☐ Azithromycin (Zithromax/Z-Pak) ☐ Anti-virals ☐ Lopinavir/Ritonavir
☐ Oseltamivir (Tamiflu) ☐ Tylenol (paracetamol/acetaminophen) ☐ Ibuprofen, naproxen, or other NSAIDs
☐ Aspirin ☐ Antiplatelet agents other than aspirin ☐ Metformin ☐ Vitamin D ☐ Anticoagulation
☐ Other ☐ Unknown ☐ None

Steroid dosing, in prednisone dose equivalents

Note: 3 mg of dexamethasone is equivalent to 20 mg of prednisone, so any dose of dexamethasone of more than 3 mg/day (21 mg/week) would be equivalant to more than 20 mg of prednisone/day.

◯ 20 mg/day or below [low dose]
◯ 10 mg/day or below [low dose]
◯ More than 10 mg/day up to 20 mg/day
◯ More than 20 mg/day but less than 1mg/kg/day
◯ Equal to or greater than 1 mg/kg/day
◯ Unknown

Please specify which immunosuppressant(s). Check all that apply.

☐ Cyclosporine
☐ Tacrolimus (Prograf)
☐ Sirolimus
☐ Everolimus
☐ Azathioprine (Imuran)
☐ Leflunomide
☐ Mycophenolate mofetil (CellCept)
☐ Mercaptopurine (6-MP)
☐ Ustekinumab
☐ Vedolizumab
☐ Methotrexate
☐ Sulfasalazine
☐ Cyclophosphamide
☐ Infliximab
☐ Etanercept
☐ Adalimumab
☐ Certolizumab
☐ Golimumab
☐ Ruxolitinib (Jakafi)
☐ Tofacitinib (Xeljanz)
☐ Oclacitinib
☐ Baricitinib
☐ Peficitinib
☐ Fedratinib (Inrebic)
☐ Upadacitinib
☐ Other
☐ Unknown

Please specify what other immunosuppressants

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Aspirin dosing	◯ Low dose (less than 200 mg/day) ◯ Full dose ◯ Unknown
Which anticoagulants were used? Check all that apply.	☐ Vitamin K antagonists (e.g., warfarin) ☐ Low-molecular weight heparin (e.g., enoxaparin [Lovenox]) ☐ Unfractionated heparin ☐ Direct thrombin inhibitors (e.g., argatroban, dabigatran [Pradaxa]) ☐ Direct factor Xa inhibitors (e.g., apixaban [Eliquis], rivaroxaban [Xarelto]) ☐ Fondaparinux ☐ Unknown ☐ Other
Why were anticoagulants being used?	◯ Prophylaxis ◯ Therapeutic dosing ◯ Unknown
Please specify what other anticoagulants Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Please specify what other medications Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Did the patient receive G-CSF within two weeks of the COVID-19 diagnosis?	◯ No ◯ Yes, Prophylactic G-CSF use (within 1-3 days of completion of chemo) ◯ Yes, Therapeutic G-CSF use (later than 1-3 days after chemo or during a neutropenic hospitalization) ◯ Other ◯ Unknown
Please specify what other G-CSF Do not record any PHI in this field. As a reminder, this includes all elements of date other than year.	_____
Additional details about medications that the patient may have been taking (e.g., specific drug names; if taking NSAIDs or corticosteroids, how long, how much; etc.) If it is easy to copy a full medication list from your EMR, please do so here. Do not record any PHI in this field. As a reminder, this includes all elements of date other than year.	_____
Did the patient have an influenza vaccine this season?	◯ No ◯ Yes ◯ Unknown

Has the patient ever had a BCG vaccine?	◯ No ◯ Yes ◯ Unknown
Patient RH blood type	◯ Rh+ ◯ Rh- ◯ Unknown
Patient ABO blood type	◯ A ◯ B ◯ AB ◯ O ◯ Unknown

Comorbidities

In this section, please report on any pre-existing conditions other than cancer that were present prior to the COVID-19 illness.

Significant comorbidities (other than cancer).

Check all that apply. If you do not know specific diagnoses, ok to choose the "NOS" categories (e.g., Pulmonary disease, NOS).

Immune suppression is defined as outpatient use of prednisone (10mg/d or greater), use of chemotherapy, use of nonsteroidal immunosuppressive agents for solid organ transplant or for an autoimmune disease.

- ☐ Immune suppression (see definition)
- ☐ HIV +/- AIDS
- ☐ Pulmonary disease, NOS
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Obstructive sleep apnea (OSA)
- ☐ Radiation pneumonitis
- ☐ ICI pneumonitis
- ☐ Cardiac disease, NOS
- ☐ Hypertension (high blood pressure; HTN)
- ☐ Hyperlipidemia (high cholesterol)
- ☐ Coronary artery disease (CAD)
- ☐ Congestive heart failure (CHF) including HFpEF and HFrEF
- ☐ Cardiac arrhythmia, NOS
- ☐ Atrial fibrillation
- ☐ Peripheral vascular disease (PVD/PAD)
- ☐ History of cerebrovascular accident (CVA; stroke)
- ☐ Pulmonary embolism (PE)
- ☐ Deep venous thrombosis (DVT)
- ☐ Renal disease, NOS
- ☐ Chronic renal insufficiency (CRI/CKD)
- ☐ End-stage renal disease (ESRD), not on dialysis
- ☐ ESRD, on dialysis
- ☐ Liver disease, NOS
- ☐ Cirrhosis
- ☐ Other organs and conditions
- ☐ Dementia
- ☐ Alcoholism
- ☐ Diabetes mellitus
- ☐ Metabolic syndrome
- ☐ Obesity
- ☐ Morbid obesity (BMI > 40 or BMI > 35 with obesity-related health conditions)
- ☐ Seasonal allergies
- ☐ Inflammatory bowel disease (IBD)
- ☐ Rheumatologic/Autoimmune disease
- ☐ History of hematopoietic transplant (bone marrow or stem cell)
- ☐ History of solid organ transplant
- ☐ Other
- ☐ Unknown
- ☐ None

What is the patient's CD4+ T-cell count?

_____

What is the patient's viral load, in copies/mL?

_____

Please consider reporting this patient to the Secure-IBD Registry as well.

Please specify what other significant comorbidities

Do not record any PHI in this field. As a reminder, this includes all elements of date other than year.

_____

Does the patient have a baseline chronic O2 requirement?

- ◯ Yes, patient requires chronic supplemental O2
- ◯ No, patient does not require supplemental O2
- ◯ Unknown

Number of comorbid conditions requiring active therapy.	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 or more ◯ Unknown

Additional comments about comorbidities.

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Free text entry (optional)

Comments

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

COVID-19 Diagnosis and Course of Illness

On this page, please give details about the initial presentation and course of COVID-19 illness. Since the clinical course may be prolonged and unpredictable, we strongly encourage you to return to add follow-up information (through a separate form that will soon be available in the queue).

Once you've filled out this form, you must click SUBMIT to save and continue to the next form. You may return later and edit your responses using the survey queue link. If you wish to navigate to another form without saving, use the survey queue button at the top right corner.

Please do not record any PHI in this survey, including dates! This registry is not exempted from ordinary HIPAA requirements.

Timestamp for the second form

_____

Is this form being filled out during the COVID-19 illness, or retrospectively?

Unless you know that the patient has either recovered from COVID-19 (with or without comlications) or died from COVID-19, you should select "during the COVID-19 illness".

- ◯ During the illness
- ◯ After the course of illness (retrospectively)

COVID-19 Details - Mandatory

What year was the patient diagnosed with COVID-19 in?

- ◯ 2019
- ◯ 2020

How long ago was the patient's COVID-19 diagnosis (to the best of your knowledge)?

- ◯ Within past 1 week
- ◯ Within past 1 to 2 weeks
- ◯ Within past 2 to 4 weeks
- ◯ Within past 4 to 8 weeks
- ◯ Within past 8 to 12 weeks
- ◯ Within past 3 to 6 months
- ◯ More than 6 months ago
- ◯ Unknown

Diagnostic Information

Why did the patient come to be evaluated for SARS-CoV-2 or COVID-19?

- ◯ Symptoms
- ◯ Screening prior to a procedure
- ◯ Screening prior to a systemic anti-cancer treatment
- ◯ Screening due to a high-risk situation (e.g., known exposure)
- ◯ Other
- ◯ Unknown

Why did the patient come to be evaluated for SARS-CoV-2 or COVID-19? Check all that apply.

- ☐ Symptoms
- ☐ Screening prior to a procedure
- ☐ Screening prior to a systemic anti-cancer treatment
- ☐ Screening due to a high-risk situation (e.g., known exposure)
- ☐ Screening required for public health reasons (e.g., prior to nursing home placement)
- ☐ Other
- ☐ Unknown

Please specify what other reason for COVID-19 evaluation

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Which symptoms and/or signs were present upon initial presentation? Check all that apply.

- ☐ Fatigue/Malaise
- ☐ Fever
- ☐ Cough
- ☐ Productive cough (with sputum)
- ☐ Dyspnea (SOB)
- ☐ Myalgias
- ☐ Arthralgias
- ☐ Sore throat
- ☐ Headache
- ☐ Altered mental status (AMS)
- ☐ Loss of sense of smell (anosmia)
- ☐ Loss of taste (ageusia)
- ☐ Rhinorrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Abdominal discomfort (other than frank abdominal pain)
- ☐ Abdominal pain
- ☐ LFT abnormalities
- ☐ Cardiac involvement
- ☐ Conjunctivitis
- ☐ Other
- ☐ None (patient was asymptomatic)

Please specify other symptoms.

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Was the patient tested as part of a pre-treatment or pre-procedure screening program?

- ◯ No
- ◯ Yes
- ◯ Unknown

COVID-19 diagnosis

Note: if the patient ever had a positive laboratory result, please choose "laboratory-confirmed". This should be checked even if the positive test is from another facility and you do not have a hard copy of the results.

- ◯ Suspected based on symptoms
- ◯ Suspected based on contact with confirmed case
- ◯ Suspected based on CXR findings
- ◯ Suspected based on CT scan findings
- ◯ Laboratory-confirmed
- ◯ Unknown

Please describe the imaging abnormalities.

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Did the patient have a negative laboratory test despite having symptoms or signs supportive of the COVID-19 diagnosis?

- ◯ Yes
- ◯ No
- ◯ Unknown

Please provide additional details, including the type of COVID-19 test.

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Additional comments about COVID-19 symptoms and diagnosis.

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Initial Severity and Course of Illness

Initial severity of COVID-19

Note 1: this is probably the most important single piece of information that we are gathering, please try not to answer "unknown" if at all possible.

Note 2: if hospitalization or ICU admission were indicated but the patient was not actually admitted, you should still select that box. For example, for a patient who arrives at the ED with critical hypoxia that would ordinarily indicate a need for mechanical ventilation, but is transitioned to home hospice immediately, you should still select the severe checkbox.

Note 3: if the patient is diagnosed while in the hospital and is asymptomatic (e.g., as screening prior to nursing home placement), answer this question as if they were presenting as an outpatient.

- ◯ Mild (no hospitalization required)
- ◯ Moderate (hospitalization indicated)
- ◯ Severe (ICU admission indicated)
- ◯ Unknown

Did the patient experience a cytokine storm or cytokine release syndrome that was specifically documented in the patient's chart?

- ◯ No
- ◯ Yes
- ◯ Unknown

Was the patient ever hospitalized during their course of illness?

If the patient was hospitalized more than once, please report on the index hospitalization and make a note in the comments about the other hospitalization(s).

- ◯ No
- ◯ Yes - admitted to floor
- ◯ Yes - admitted to floor and then transferred to the ICU
- ◯ Yes - admitted directly to the ICU
- ◯ Unknown

If known, how long was the length of stay, in days?

If the patient is still hospitalized, enter 9999 here.

_____

If known, how long was the length of stay prior to transfer to the ICU, in days?

_____

If known, how long was the ICU length of stay, in days?

If the patient is still in the ICU, enter 9999 here.

_____

What is the patient's current location?

- ◯ Outpatient - new COVID-19 diagnosis
- ◯ Outpatient - follow up
- ◯ ER - new COVID-19 diagnosis
- ◯ ER - Follow up
- ◯ Hospitalized (non-ICU) - new admit
- ◯ Hospitalized (non-ICU) - continued
- ◯ ICU - new admit
- ◯ ICU - continued
- ◯ None - patient is deceased

Please provide additional details about the proximal cause of death.

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Complications

Systemic complications occurring during the COVID-19 illness. Check all that apply. If there were no systemic complications, please check "None".

- ☐ Bleeding
- ☐ Disseminated intravascular coagulation (DIC)
- ☐ Multiorgan failure
- ☐ Sepsis
- ☐ Other
- ☐ None
- ☐ Unknown

Please specify the type of bleeding. Check all that apply.

- ☐ Major bleeding (requiring multiple RBCs transfusions or ICU admit)
- ☐ Non-major but clinically relevant bleed
- ☐ Minor bleed (without transfusion need)
- ☐ CNS hemorrhage, extensive
- ☐ CNS hemorrhage, limited
- ☐ Other
- ☐ Unknown

Please specify further details about bleeding.

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

How definite was the DIC diagnosis?

- ◯ Definite
- ◯ Suspected
- ◯ Unknown

Which of the following were used to treat the DIC?

- ◯ Plasma (FFP)
- ◯ Cryoprecipitate
- ◯ None
- ◯ Unknown
- ◯ Other

Please provide further details about DIC, including clinical manifestations.

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Please specify other systemic complications. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Did the patient require supplemental O2 during the course of illness?	◯ No ◯ Yes ◯ Unknown
Was there an institutional policy in place to refuse intubation for patients with metastatic cancer, at the time when this patient required supplemental O2?	◯ No ◯ Yes ◯ Unknown
Pulmonary complications occurring during the COVID-19 illness. Check all that apply. If there were no pulmonary complications, please check "None". Note: the distinction between pneumonia and pneumonitis can often be very subtle and subjective. Radiology notes may say pneumonitis and clinical notes may say pneumonia. Please use your best judgment.	☐ Respiratory failure ☐ Pneumonitis ☐ Pneumonia ☐ Acute respiratory distress syndrome (ARDS) ☐ Pulmonary embolism (PE) ☐ Pleural effusion ☐ Empyema ☐ Other ☐ None ☐ Unknown
Which of the following supplemental O2 interventions did the patient require? Select the most invasive intervention required during the course of illness.	◯ Nasal cannula or face mask with standard O2 ◯ High-flow nasal cannula or blow-by ◯ Non-rebreather ◯ CPAP ◯ BiPAP ◯ Intubation ◯ Unknown
Were the Berlin criteria formally assessed?	◯ No ◯ Yes ◯ Unknown/Unsure
Berlin criteria. The Berlin criteria are based on a decreased PaO2/FiO2 ratio: -mild ARDS: 201 - 300 mmHg (≤ 39.9 kPa) -moderate ARDS: 101 - 200 mmHg (≤ 26.6 kPa) -severe ARDS: ≤ 100 mmHg (≤ 13.3 kPa) Note that the Berlin definition requires a minimum positive end expiratory pressure (PEEP) of 5 cmH2O for consideration of the PaO2/FiO2 ratio. This degree of PEEP may be delivered noninvasively with CPAP to diagnose mild ARDS. Click this link to access a calculator for PaO2/FiO2 ratio (opens a new window)	◯ Mild ◯ Moderate ◯ Severe ◯ Unknown
Please specify other pulmonary complications. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____

Cardiovascular complications occurring during the COVID-19 illness. Check all that apply. If there were no cardiovascular complications, please check "None".	☐ Hypotension ☐ Myocardial infarction ☐ Other cardiac ischemia ☐ Atrial fibrillation ☐ Ventricular fibrillation ☐ Other cardiac arrhythmia ☐ Cardiomyopathy ☐ Congestive heart failure (CHF) ☐ Pulmonary embolism (PE) ☐ Deep venous thrombosis (DVT) ☐ Superficial venous thrombosis (SVT) ☐ Cerebrovascular accident (CVA; stroke) ☐ Thrombosis, NOS ☐ Other ☐ None ☐ Unknown
Did the patient require pressors?	◯ No ◯ Yes ◯ Unknown
Please specify other cardiac complications. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Gastrointestinal complications occurring during the COVID-19 illness. Check all that apply. If there were no GI complications, please check "None".	☐ Acute hepatic injury ☐ Ascites ☐ Bowel obstruction ☐ Bowel perforation ☐ Ileus ☐ Peritonitis ☐ Other ☐ None ☐ Unknown
Please specify other GI complications. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Other complications occurring during the COVID-19 illness. Check all that apply. If there were no other complications, please check "None".	☐ Acute kidney injury ☐ Seizures ☐ Gangrene ☐ Thrombosis, NOS ☐ Other ☐ None ☐ Unknown
Please specify other complications. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____

Clinical Status

Current COVID-19 status

Fully recovered means that the patient has returned to their baseline functional status and repeat SARS-CoV-2 testing, if obtained, is negative. If they are on medications to treat sequelae or have functional compromise (e.g., impaired pulmonary function) but are not considered to have active infection, they should be considered to have recovered with complications.

- ◯ Fully recovered
- ◯ Recovered with complications
- ◯ Ongoing infection
- ◯ Died
- ◯ Unknown

Final COVID-19 status

Fully recovered means that the patient has returned to their baseline functional status and repeat SARS-CoV-2 testing, if obtained, is negative. If they are on medications to treat sequelae or have functional compromise (e.g., impaired pulmonary function) but are not considered to have active infection, they should be considered to have recovered with complications.

- ◯ Fully recovered
- ◯ Recovered with complications
- ◯ Died
- ◯ Unknown

Please provide additional details about the proximal cause of death.

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Approximately how many days elapsed between COVID-19 diagnosis and death?

If this information is unknown to you, please enter 9999 here.

_____

Current clinical status

- ◯ Outpatient - No symptoms
- ◯ Outpatient - Mild symptoms
- ◯ Outpatient - Moderate symptoms
- ◯ Outpatient - Severe symptoms
- ◯ Inpatient - Near Recovery
- ◯ Inpatient - Moderately ill
- ◯ Inpatient - Severely ill
- ◯ Critical (ICU) - Severely ill, not requiring ventilator support
- ◯ Critical (ICU) - Severely ill, intubated
- ◯ Other
- ◯ Unknown

Please specify other current clinical status

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Worst clinical status. Report the worst clinical presentation during the COVID-19 illness or the current clinical status if this is the only known status. If the patient died, this should be the highest level of care that they received prior to the time of death.	◯ Outpatient - No symptoms ◯ Outpatient - Mild symptoms ◯ Outpatient - Moderate symptoms ◯ Outpatient - Severe symptoms ◯ Inpatient - Moderately ill ◯ Inpatient - Severely ill ◯ Critical (ICU) - Severely ill, did not require ventilator support ◯ Critical (ICU) - Severely ill, intubated ◯ Other ◯ Unknown
Please specify worst clinical status Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Current severity of COVID-19 complications. Check all that apply.	☐ No complications ☐ Mild complications (mimimal symptoms from complications) ☐ Moderate complications (moderate symptoms from complications) ☐ Serious complications (symptoms substantially impact the patient's functional status or disabling physical functioning) ☐ Other ☐ Unknown
Please specify other current severity of COVID-19 complications Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Worst severity of COVID-19 complications. Check all that apply.	☐ None (patient was asymptomatic) ☐ Mild complications (mimimal symptoms from complications) ☐ Moderate complications (moderate symptoms from complications) ☐ Serious complications (symptoms substantially impact the patient's functional status or disabling physical functioning) ☐ Other ☐ Unknown
Please specify other worst severity of COVID-19 complications Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____

Please consider returning to add a new form once final status has been determined. In order to do this, click on the button named "Survey Queue" in the top right-hand corner of the screen. This will open a window where you can choose "Get link to my survey queue". Use this link to return to the survey at any time to add additional updated information.

COVID-19 Details - Optional

Would you like to answer additional COVID-19 detail questions? This is optional but will really help us understand the granular details better.

- ◯ Yes
- ◯ No

If it has been at least 30 days from the presumptive or laboratory-proven COVID-19 diagnosis, was the patient alive 30 days after diagnosis?

Note: this question is required for members of the CCC19 consortium; optional but strongly encouraged for all others.

- ◯ Yes
- ◯ No
- ◯ N/A - it has been fewer than 30 days since COVID-19 diagnosis
- ◯ Unknown

Baseline laboratory values at the time of or closest to the date of the COVID-19 diagnosis

If the laboratory value (e.g., IL-6 level) was not available at the time of presentation, please enter the earliest known result, if known.

At what time point were labs drawn?

This information is important to build predictive models of disease severity based on lab values. Your answer should be based on common labs (CBC, CMP, BNP, etc.) - not necessarily send-out labs that were drawn later in the course of COVID-19 illness.

- ◯ At the time of initial COVID-19 diagnosis
- ◯ At the time of a change in clinical status (hospitalization)
- ◯ At the time of a change in clinical status (other than hospitalization)
- ◯ Labs were not drawn or are not available for review
- ◯ Other
- ◯ Unknown

Please specify what other time point labs were drawn

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

CBC values at presentation

	Low	Normal	High	Not tested	Unknown
Total WBC count	◯	◯	◯	◯	◯
Absolute lymphocyte count (ALC) - less than 1500/uL should be considered low	◯	◯	◯	◯	◯
Absolute neutrophil count (ANC)	◯	◯	◯	◯	◯
Absolute eosinophil count (AEC)	◯	◯	◯	◯	◯
Hemoglobin	◯	◯	◯	◯	◯
Platelets	◯	◯	◯	◯	◯

Total WBC count in 10^9/L

_____

Absolute lymphocyte count per uL

_____

Absolute neutrophil count per uL

_____

Absolute eosinophil count per uL

_____

Hemoglobin level in g/dL

_____

Platelet count, 10^3/uL

_____

Other lab values at presentation

	Normal	Abnormal	Not tested	Unknown
Creatinine	◯	◯	◯	◯
Total bilirubin	◯	◯	◯	◯
AST	◯	◯	◯	◯
ALT	◯	◯	◯	◯
PT	◯	◯	◯	◯
aPTT	◯	◯	◯	◯
Fibrinogen	◯	◯	◯	◯
D-Dimer	◯	◯	◯	◯
LDH	◯	◯	◯	◯
Troponin I (TnI)	◯	◯	◯	◯
High-sensitivity troponin	◯	◯	◯	◯
BNP	◯	◯	◯	◯
CRP	◯	◯	◯	◯
IL-6	◯	◯	◯	◯
Other (free text will open for more details below)	◯	◯	◯	◯

Please provide measured creatinine level in mg/dL

_____

Please provide measured total bilirubin value in mg/dL

_____

Please provide measured AST/SGOT value in units/L

_____

Please provide measured ALT/SGPT value in units/L

_____

Please report measured PT value in seconds. If above the maximum range, enter "999".

_____

Please report measured aPTT value in seconds. If above the maximum range, enter "999".

_____

Please report measured fibrinogen value in mg/dL (conventional units).

_____

Please report measured D-Dimer value along with units, which often differ between labs.	_____
Please report measured LDH value along with units, which often differ between labs.	_____
Please report measured TnI value in ng/mL. Only record values greater than or equal to 0.05 ng/mL.	_____
Please report measured high sensitivity troponin value in pg/mL.	_____
Please report measured BNP value in pg/mL.	_____
Please provide measured CRP value along with units, which often differ between labs.	_____
Please report measured IL-6 value in pg/mL	_____
Please provide more details including numeric values, if you are able. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____

Co-infections

Was another co-infection suspected within two weeks prior or up to two weeks after the COVID-19 diagnosis?	◯ No ◯ Yes ◯ Unknown
Were there other co-infections diagnosed? Check all that apply.	☐ Viral, NOS ☐ Influenza A ☐ Influenza B ☐ Ordinary coronavirus, NOS ☐ Rhinovirus ☐ RSV ☐ Bacterial infection, NOS ☐ Gram-positive bacteria, NOS ☐ Pneumococcal pneumonia ☐ Gram-negative bacteria, NOS ☐ Fungal, NOS ☐ Aspergillus culture-confirmed ☐ Aspergillus suspected (galactomannan positive) ☐ Tests are pending ☐ Other ☐ Unknown ☐ None (Terminology: SNOMED)
Please specify what other co-infections were diagnosed Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____

COVID-19 Treatment

COVID-19 treatment, including pre-existing drugs that were continued during the COVID-19 diagnosis. Check all that apply.	☐ Chloroquine ☐ Hydroxychloroquine (Plaquenil) ☐ Anti-virals ☐ Atazanavir ☐ Lopinavir/Ritonavir ☐ Oseltamivir (Tamiflu) ☐ Remdesivir ☐ Azithromycin (Zithromax/Z-Pak) ☐ Systemic corticosteroids (will prompt for additional details) ☐ Statins ☐ Baricitinib ☐ Tocilizumab ☐ Other interleukin inhibitors (will prompt for additional details) ☐ JAK inhibitors (will prompt for additional details) ☐ TNF alpha inhibitors (will prompt for additional details) ☐ Plasma from recovered individuals (convalescent plasma) ☐ Anticoagulation ☐ Aspirin ☐ Antiplatelet agents other than aspirin ☐ Extracorporeal membrane oxygenation (ECMO) ☐ Continuous renal replacement therapy (CRRT) ☐ Other ☐ Unknown ☐ None ☐ DEPRECATED
Aspirin dosing	◯ Low dose (less than 200 mg/day) ◯ Full dose ◯ Unknown
Steroid type. Check all that apply.	☐ Dexamethasone (Decadron) ☐ Hydrocortisone (Cortef) ☐ Methylprednisolone (Solumedrol) ☐ Prednisolone ☐ Prednisone
Steroid dosing, in prednisone dose equivalents Note: 3 mg of dexamethasone is equivalent to 20 mg of prednisone, so any dose of dexamethasone of more than 3 mg/day (21 mg/week) would be equivalant to more than 20 mg of prednisone/day.	◯ 20 mg/day or below [low dose] ◯ 10 mg/day or below [low dose] ◯ More than 10 mg/day up to 20 mg/day ◯ More than 20 mg/day but less than 1mg/kg/day ◯ Equal to or greater than 1 mg/kg/day ◯ Unknown
Please provide more details: prednisone dose equivalents (e.g., 1 mg/kg) and duration of steroid therapy. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____

Interleukin inhibitor treatment other than tocilizumab. Check all that apply.	☐ anakinra ☐ basiliximab ☐ briakinumab ☐ brodalumab ☐ canakinumab ☐ daclizumab ☐ guselkumab ☐ ixekizumab ☐ rilonacept ☐ risankizumab ☐ sarilumab ☐ secukinumab ☐ siltuximab ☐ sirukumab ☐ DEPRECATED ☐ tildrakizumab ☐ ustekinumab
JAK inhibitor treatment. Check all that apply.	☐ Ruxolitinib (Jakafi) ☐ Tofacitinib (Xeljanz) ☐ Oclacitinib ☐ Baricitinib ☐ Peficitinib ☐ Fedratinib (Inrebic) ☐ Upadacitinib
Tumor necrosis factor alpha (TNF-α) inhibitor treatment. Check all that apply.	☐ Adalimumab ☐ Afelimomab ☐ Certolizumab pegol ☐ Etanercept ☐ Golimumab ☐ Infliximab ☐ Opinercept
Has the patient received any dose or type of anticoagulants at any time during the COVID-19 diagnosis? Check all that apply. (Examples: unfractionated heparin, LMWH, fondaparinux, direct thrombin inhibitor, Vitamin K antagonist, or DOAC) ATE: arterial thromboembolism; VTE: venous thromboembolism	☐ Prophylactic use (without the presence of a VTE either as an inpatient or outpatient) ☐ DEPRECATED ☐ Therapeutic use (for known VTE diagnosis) ☐ Therapeutic use (for known ATE diagnosis) ☐ Therapeutic use in the absence of any thrombosis (e.g., for prevention of stroke in atrial fibrillation) ☐ For DIC during hospitalization ☐ None (patient did not receive any anticoagulants) ☐ Unknown ☐ Other
Please specify the type and indication of other anticoagulants Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____

Which anticoagulants were used? Check all that apply.	☐ Vitamin K antagonists (e.g., warfarin) ☐ Low-molecular weight heparin (e.g., enoxaparin [Lovenox]) ☐ Unfractionated heparin ☐ Direct thrombin inhibitors (e.g., argatroban, dabigatran [Pradaxa]) ☐ Direct factor Xa inhibitors (e.g., apixaban [Eliquis], rivaroxaban [Xarelto]) ☐ Fondaparinux ☐ Unknown ☐ Other
Please specify what other anticoagulants Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Was any of the COVID-19 treatment given as part of a clinical trial?	◯ No ◯ Yes ◯ Unknown

COVID-19 clinical trial treatment. Check all that apply. If you do not know which drug(s) were given on clinical trial, please check "Unknown". If you are not able to disclose drug names due to institutional restrictions, please check "Other".	☐ Chloroquine ☐ Hydroxychloroquine (Plaquenil) ☐ Anti-virals ☐ Atazanavir ☐ Lopinavir/Ritonavir ☐ Oseltamivir (Tamiflu) ☐ Remdesivir ☐ Azithromycin (Zithromax/Z-Pak) ☐ Systemic corticosteroids ☐ Statins ☐ Anakinra ☐ Baricitinib ☐ Basiliximab ☐ briakinumab ☐ brodalumab ☐ canakinumab ☐ daclizumab ☐ guselkumab ☐ ixekizumab ☐ rilonacept ☐ risankizumab ☐ sarilumab ☐ secukinumab ☐ siltuximab ☐ sirukumab ☐ tildrakizumab ☐ tocilizumab ☐ ustekinumab ☐ adalimumab ☐ afelimomab ☐ certolizumab pegol ☐ etanercept ☐ golimumab ☐ infliximab ☐ opinercept ☐ Plasma from recovered individuals (convalescent plasma) ☐ Plasma from recovered individuals (convalescent plasma) ☐ Other ☐ Unknown
Please specify what other clinical trial treatment. (Note: some institutions have restrictions on sharing of this information, please check with your institutional official if you have any questions.) Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Additional COVID-19 treatment comments, e.g. specific doses. Please provide further information here. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Did the patient receive any PRBC transfusions?	◯ No ◯ Yes ◯ Unknown

Free text entry (optional)

Comments

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

Cancer Details

This page collects data on the cancer diagnosis as well as treatment details for those patients actively receiving or having recently received anti-cancer therapy.

Once you've filled out this form, you must click SUBMIT to save and continue to the next form. You may return later and edit your responses using the survey queue link. If you wish to navigate to another form without saving, use the survey queue button at the top right corner.

Please do not record any PHI in this survey, including dates! This registry is not exempted from ordinary HIPAA requirements.

Timestamp for the third form

_____

Cancer-specific data - Mandatory

Cancer type. If the patient has multiple primaries, please report on the cancer that was most recently treated.

- ◯ Malignant Solid Neoplasm, NOS
- ◯ Adrenocortical Carcinoma
- ◯ Anal Cancer
- ◯ Appendix Cancer
- ◯ Bile Duct Cancer (Cholangiocarcinoma)
- ◯ Bladder Cancer
- ◯ Bone cancer, NOS
- ◯ Brain Cancer - benign (e.g., meningioma)
- ◯ Brain Cancer - low-grade glioma
- ◯ Brain Cancer - high-grade glioma (e.g., GBM)
- ◯ Brain (CNS) Cancer, NOS
- ◯ Breast Cancer
- ◯ Cervical Cancer
- ◯ Colon Cancer
- ◯ Colon/Rectum Cancer
- ◯ Esophagus Cancer
- ◯ Ewing Sarcoma
- ◯ Fallopian Tube Cancer
- ◯ Gallbladder Cancer
- ◯ Germ Cell Tumor
- ◯ GIST
- ◯ Head and Neck Cancer
- ◯ Invasive Cutaneous SCC (do not record localized SCC)
- ◯ Invasive Cutaneous BCC (do not record localized BCC)
- ◯ Mesothelioma
- ◯ Ill Defined/Cancer of Unknown Primary
- ◯ Liver Cancer (HCC)
- ◯ Lung Cancer, NOS
- ◯ Melanoma
- ◯ Merkel Cell
- ◯ Nasopharyngeal Carcinoma
- ◯ Neuroblastoma
- ◯ Neuroendocrine tumor (NET) or Carcinoid
- ◯ Non Small Cell Lung Cancer (NSCLC)
- ◯ Osteosarcoma
- ◯ Ovarian Cancer
- ◯ Pancreatic Cancer
- ◯ Parathyroid Cancer
- ◯ Penis Cancer
- ◯ Peritoneum Cancer
- ◯ Placenta Cancer (incl. Choriocarcinoma)
- ◯ Prostate Cancer
- ◯ Rectum and Rectosigmoid Cancer
- ◯ Renal Kidney Cancer (RCC)
- ◯ Renal Pelvis Cancer
- ◯ Retinoblastoma
- ◯ Rhabdomyosarcoma
- ◯ Scrotum Cancer
- ◯ Small Cell Lung Cancer
- ◯ Small Intestine Cancer
- ◯ Soft Tissue Sarcoma, NOS
- ◯ Stomach (Gastric) Cancer
- ◯ Testis Cancer
- ◯ Thymus Cancer
- ◯ Thyroid Cancer
- ◯ Uterus (Endometrial) Cancer
- ◯ Vagina Cancer
- ◯ Vascular Sarcoma, NOS
- ◯ Vulva Cancer
- ◯ Wilms Tumor
- ◯ Malignant Hematologic Neoplasm, NOS
- ◯ Acute Leukemia
- ◯ Acute myeloid leukemia (AML)
- ◯ Acute lymphoblastic leukemia (ALL)
- ◯ Myeloproliferative neoplasm (MPN)
- ◯ Chronic myeloid leukemia (CML)
- ◯ Myelodysplastic syndrome (MDS)

◯ Aggressive lymphoma
◯ Hodgkin lymphoma
◯ Non-Hodgkin lymphoma (NHL)
◯ Diffuse large B-cell lymphoma (DLBCL)
◯ Mantle cell lymphoma (MCL)
◯ Burkitt lymphoma
◯ Indolent lymphoma
◯ Follicular lymphoma
◯ Chronic lymphocytic leukemia (CLL)
◯ Marginal zone lymphoma
◯ Plasma cell dyscrasia
◯ Multiple myeloma
◯ AL amyloidosis
◯ T-cell and NK-cell neoplasm
◯ Lymphoproliferative disorder
◯ Histiocyte disorder
◯ Other
◯ Other Heme
◯ Other Solid Tumor

Please specify cancer type

_____

This code is not preferred because it is non-specific. If the patient has a myeloid-lineage acute leukemia (AML, APL, AMML, etc) please go back and select acute myeloid leukemia. If the patient has a plasma cell leukemia, please go back and select plasma cell dyscrasia. Otherwise, please enter the specific details below in the additional cancer details.

This code should only be used if you do not know the histology of the lung cancer (e.g., the patient was treated without a confirmatory biopsy) or if the histology overlaps. If you know that the cancer is NSCLC (e.g., adenocarcinoma, squamous cell carcinoma, large cell carcinoma) please go back and select that choice. If you know that the cancer is a low-grade neuroendocrine tumor (i.e., carcinoid), please go back and select carcinoid/NET. If you know that the cancer is a high-grade neuroendocrine tumor (i.e., small cell lung cancer), please go back and select SCLC. Otherwise, please enter the specific histology below in the additional cancer details.

Please consider donating data to the TERAVOLT (Thoracic cancERs international coVid 19 cOLlaboraTion) registry, as well. In order to do this, unless you are already part of a member institution, you will need to reach out to Prof. Jennifer Whisenant j.whisenant@vumc.org

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Does the patient have multiple malignancies?

This includes multiple active malignancies as well as historic cancers.

◯ No
◯ Yes
◯ Unknown

Cancer type of second malignancy. If the patient has more than two malignancies, please select the second-most recently diagnosed cancer type. If unknown or unclear, please specify in the free text box below.

- ◯ Malignant Solid Neoplasm, NOS
- ◯ Adrenocorical Carcinoma
- ◯ Anal Cancer
- ◯ Appendix Cancer
- ◯ Bile Duct Cancer (Cholangiocarcinoma)
- ◯ Bladder Cancer
- ◯ Bone cancer, NOS
- ◯ Brain Cancer - benign (e.g., meningioma)
- ◯ Brain Cancer - low-grade glioma
- ◯ Brain Cancer - high-grade glioma (e.g., GBM)
- ◯ Brain (CNS) Cancer, NOS
- ◯ Breast Cancer
- ◯ Cervical Cancer
- ◯ Colon Cancer
- ◯ Colon/Rectum Cancer
- ◯ Esophagus Cancer
- ◯ Ewing Sarcoma
- ◯ Fallopian Tube Cancer
- ◯ Gallbladder Cancer
- ◯ Germ Cell Tumor
- ◯ GIST
- ◯ Head and Neck Cancer
- ◯ Invasive Cutaneous SCC (do not record localized SCC)
- ◯ Invasive Cutaneous BCC (do not record localized BCC)
- ◯ Mesothelioma
- ◯ Ill Defined/Cancer of Unknown Primary
- ◯ Liver Cancer (HCC)
- ◯ Lung Cancer, NOS
- ◯ Melanoma
- ◯ Merkel Cell
- ◯ Nasopharyngeal Carcinoma
- ◯ Neuroblastoma
- ◯ Neuroendocrine tumor (NET) or Carcinoid
- ◯ Non Small Cell Lung Cancer (NSCLC)
- ◯ Osteosarcoma
- ◯ Ovarian Cancer
- ◯ Pancreatic Cancer
- ◯ Parathyroid Cancer
- ◯ Penis Cancer
- ◯ Peritoneum Cancer
- ◯ Placenta Cancer (incl. Choriocarcinoma)
- ◯ Prostate Cancer
- ◯ Rectum and Rectosigmoid Cancer
- ◯ Renal Kidney Cancer (RCC)
- ◯ Renal Pelvis Cancer
- ◯ Retinoblastoma
- ◯ Rhabdomyosarcoma
- ◯ Scrotum Cancer
- ◯ Small Cell Lung Cancer
- ◯ Small Intestine Cancer
- ◯ Soft Tissue Sarcoma, NOS
- ◯ Stomach (Gastric) Cancer
- ◯ Testis Cancer
- ◯ Thymus Cancer
- ◯ Thyroid Cancer
- ◯ Uterus (Endometrial) Cancer
- ◯ Vagina Cancer
- ◯ Vascular Sarcoma, NOS
- ◯ Vulva Cancer
- ◯ Wilms Tumor
- ◯ Malignant Hematologic Neoplasm, NOS
- ◯ Acute Leukemia
- ◯ Acute myeloid leukemia (AML)
- ◯ Acute lymphoblastic leukemia (ALL)
- ◯ Myeloproliferative neoplasm (MPN)
- ◯ Chronic myeloid leukemia (CML)
- ◯ Myelodysplastic syndrome (MDS)

	◯ Aggressive lymphoma ◯ Hodgkin lymphoma ◯ Non-Hodgkin lymphoma (NHL) ◯ Diffuse large B-cell lymphoma (DLBCL) ◯ Mantle cell lymphoma (MCL) ◯ Burkitt lymphoma ◯ Indolent lymphoma ◯ Follicular lymphoma ◯ Chronic lymphocytic leukemia (CLL) ◯ Marginal zone lymphoma ◯ Plasma cell dyscrasia ◯ Multiple myeloma ◯ AL amyloidosis ◯ T-cell and NK-cell neoplasm ◯ Lymphoproliferative disorder ◯ Histiocyte disorder ◯ Other ◯ Other Heme ◯ Other Solid Tumor
Please specify cancer type	_____
Multiple malignancies - further details. Please provide further details, including whether the primary cancers were synchronous or metachronous, the types of the multiple primaries, etc. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Breast cancer specific: What is the breast cancer phenotype? Check all that apply.	☐ Estrogen-receptor positive ☐ HER2 overexpressing (HER2 positive) ☐ Triple-negative breast cancer (ER, PR, and HER2 negative) ☐ Unknown
Bladder cancer specific: Has the patient ever received intravesicular BCG?	◯ No ◯ Yes ◯ Unknown
Prostate cancer specific: Gleason Score – Document the highest Gleason score (from either biopsy or radical prostatectomy - preferred if available). For example, Gleason 4 + 3 would be marked as Gleason 7.	◯ Gleason score 2 ◯ Gleason score 3 ◯ Gleason score 4 ◯ Gleason score 5 ◯ Gleason score 6 ◯ Gleason score 7 ◯ Gleason score 8 ◯ Gleason score 9 ◯ Gleason score 10 ◯ No needle core biopsy/TURP/prostatectomy performed ◯ Not applicable: Information not collected for this case ◯ Not documented in medical record or Gleason Score not assessed or unknown if assessed
Prostate cancer specific: What type of specimen was the Gleason score based on?	◯ Prostate biopsy or TURP ◯ Radical prostatectomy ◯ Metastatic site of disease ◯ Unknown

Cancer status. If the patient has multiple primaries, please report on the cancer that was most recently treated.	◯ Remission/NED ◯ Active disease, responding to treatment ◯ Active disease, stable ◯ Active disease, progressing ◯ Active disease, status unknown or not yet assessed ◯ Unknown
Was the patient on hospice prior to the COVID-19 diagnosis?	◯ No ◯ Yes ◯ Unknown
Is the patient on anti-cancer treatment? That is, was the patient receiving any treatments intended to directly or indirectly destroy cancer cells in the 3 months prior to COVID-19 diagnosis? This includes systemic therapy, surgery, radiotherapy, and transplant/cellular therapy (including prior to actual transplant/infusion).	◯ Yes ◯ No ◯ Unknown
When was the most recent anti-cancer treatment, relative to the time of COVID-19 diagnosis? Anti-cancer treatment means anything intended to directly or indirectly destroy cancer cells, including systemic therapy, surgery, radiotherapy, and transplant/cellular therapy.	◯ Less than 2 weeks prior to COVID-19 diagnosis ◯ Within 2 to 4 weeks prior to COVID-19 diagnosis ◯ Within the month to 3 months prior to COVID-19 diagnosis ◯ More than 3 months prior to COVID-19 diagnosis ◯ Unknown
When was the most recent anti-cancer treatment completed, relative to the time of COVID-19 diagnosis?	◯ Completed within 3 months prior to COVID-19 diagnosis ◯ Completed more than 3 months but less than 1 year prior to COVID-19 diagnosis ◯ Completed more than 1 year prior to COVID-19 diagnosis ◯ Never (patient never received cancer treatment prior to COVID-19 diagnosis) ◯ Unknown
Anti-cancer treatment modality. Check all that apply. For example, if a patient received concurrent chemoradiation, check cytotoxic chemotherapy and radiotherapy. Note: "Cytotoxic chemotherapy" should be selected only for drugs that have direct toxic effects on the cellular reproduction apparatus (e.g., anthracyclines, taxanes, vinca alkaloids, etc.). Note: monoclonal antibodies that do not have a direct immunostimulatory effect (e.g., rituximab, bevacizumab, etc.) should be selected as "Targeted therapy", as should immunomodulators (e.g., lenalidomide) and drugs that targeted specific cellular proteins (e.g., venetoclax, ibrutinib).	☐ Cytotoxic chemotherapy ☐ Immunotherapy ☐ Targeted therapy ☐ Endocrine therapy ☐ Radiotherapy ☐ Surgery ☐ Transplant/Cellular therapy ☐ Intravesicular therapy (e.g., BCG) ☐ Other
Did the intravesicular therapy include BCG?	◯ No ◯ Yes ◯ Unknown

Please specify other modalities. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
What immunotherapy?	◯ Anti-CTLA4 antibody ◯ Anti-PD-1 antibody (e.g., nivolumab, pembrolizumab) ◯ Anti-PD-L1 antibody (e.g., atezolizumab, avelumab) ◯ Combination of anti-CTLA4 and anti-PD-1 (e.g. ipilimumab & nivolumab) ◯ Other ◯ Unknown
Please specify what other immunotherapy Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Some targeted therapies have postulated antiviral effects. Was the patient taking any of these medications? Check all that apply.	☐ Acalabrutinib (Calquence) ☐ Dasatinib (Sprycel) ☐ Fedratinib (Inrebic) ☐ Ibrutinib (Imbruvica) ☐ Imatinib (Gleevec) ☐ Nilotinib (Tasigna) ☐ Ruxolitinib (Jakafi) ☐ Tofacitinib (Xeljanz) ☐ Other ☐ Unknown ☐ None
Please specify what other targeted therapy. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Is there a strong concern for concurrent immune-related adverse event (irAE) pneumonitis?	◯ No ◯ Possible ◯ Likely ◯ Definite irAE pneumonitis
Is there a strong concern for another concurrent irAE?	◯ Yes ◯ No
Please describe Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Does or did the radiation treatment field include the lungs to any degree?	◯ Yes ◯ No ◯ Unknown

Transplant and cellular therapy - additional information. So that we can better understand the patient's degree of immunosuppression, please provide additional details related to their prior treatment course and to their disease status when entering into transplant or cellular therapy. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Transplant & cellular therapy - what type of therapy?	◯ Autologous stem cell transplant ◯ Allogeneic SCT (donor/type unknown) ◯ MUD allogeneic SCT ◯ MRD allogeneic SCT ◯ Haplo allogeneic SCT ◯ Cord blood allogeneic SCT ◯ CAR-T cells ◯ Other ◯ Unknown
Please specify what other type of transplant or cellular therapy Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Transplant & cellular therapy - how far out from treatment?	◯ During prep (prior to transplant) ◯ 0-20 days ◯ 21-100 days ◯ 101-365 days ◯ More than 1 year ◯ Unknown
Anti-cancer treatment - additional information. Please give more details here about the specific treatment(s) that the patient has been receiving, including drug and/or regimen names. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Anti-cancer treatment intent	◯ Curative ◯ Palliative ◯ Unclear or unknown
Current anti-cancer treatment context. Note that the language for treatment context differs for solid and hematologic malignancies. The first set of choices are more commonly used for solid tumors, and the last three (induction, consolidation, maintenance) for hematologic malignancy.	◯ Curative therapy, NOS ◯ Neoadjuvant ◯ Adjuvant ◯ Non-curative therapy, NOS ◯ 1st line non-curative therapy ◯ 2nd line non-curative therapy ◯ Subsequent line non-curative therapy ◯ Induction ◯ Consolidation ◯ Maintenance ◯ Other ◯ Unknown

Please specify other treatment context

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Prostate cancer specific: Has the patient had a bilateral orchiectomy?

◯ No
◯ Yes
◯ Unknown

Prostate cancer specific: Was the patient on androgen deprivation therapy within 6 months of a positive SARS-CoV-2 test or presumed positive COVID-19 disease?

HINT: Androgen deprivation therapy is typically administered in the form of an injection given every 1, 3, 4, or 6 months. Agents largely include: degarelix, leuprolide, goserelin, triptorelin, buserelin.

◯ No
◯ Yes
◯ Unknown

Prostate cancer specific: Please check all the prostate cancer therapies that the patient received within 3 months of a positive SARS-CoV-2 test or presumed positive COVID-19 disease. More than one option can be selected.

☐ Bicalutamide (Casodex)
☐ Flutamide
☐ Nilutamide
☐ Abiraterone
☐ Enzalutamide (Xtandi)
☐ Apalutamide (Erleada)
☐ Darolutamide (Nubeqa)
☐ Docetaxel (Taxotere)
☐ Cabazitaxel (Jevtana)
☐ Carboplatin
☐ Mitoxantrone
☐ Sipuleucel-T
☐ Radium-223
☐ Olaparib
☐ Rucaparib
☐ Pembrolizumab
☐ Clinical trial
☐ Other agent
☐ None of the above
☐ Unknown

Please specify clinical trial details.

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Please specify other agent(s).

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Cancer-specific data - Optional

Would you like to answer additional cancer-specific questions? This is optional but will really help us understand the granular details better.

- ◯ Yes
- ◯ No

Stage at cancer diagnosis.

If the patient has multiple primaries, please report on the cancer that was most recently treated.

If the patient was initially diagnosed with in situ cancer but then developed invasive disease, please report the stage at the time of invasive disease diagnosis.

For hematologic malignancies that are not anatomically staged (e.g., leukemias, myeloma), select localized or disseminated based on the distribution of the disease. For example, multiple myeloma would be disseminated, whereas a solitary plasmacytoma would be localized.

- ◯ 0 (in situ)
- ◯ I
- ◯ II
- ◯ III
- ◯ IV
- ◯ Localized
- ◯ Disseminated
- ◯ Other
- ◯ Unknown

Please specify other stage at cancer diagnosis

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Did the patient have metastatic cancer at the time of COVID-19 diagnosis?

- ◯ No
- ◯ Yes
- ◯ Not applicable (e.g., patient has a liquid hematologic malignancy)
- ◯ Unknown

What were the sites of metastatic disease? Please check all that apply.

- ☐ Bone
- ☐ Brain
- ☐ Distant lymph nodes
- ☐ Liver
- ☐ Lung
- ☐ Other sites
- ☐ Generalized metastases such as carcinomatosis, malignant pleural effusion, malignant ascites
- ☐ Unknown

Please specify additional sites of metastatic cancer

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

When was the patient's cancer diagnosed? If the patient has multiple primaries, please report on the cancer that was most recently treated.

- ◯ Within the past year
- ◯ Within the past 5 years
- ◯ More than 5 years ago
- ◯ Unknown

Is the patient on a clinical trial?

- ◯ No
- ◯ Yes
- ◯ Unknown

Please provide additional details if you can. Note: some institutions have restrictions on sharing of this information, please check with your institutional official if you have any questions.

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Additional details about cancer diagnosis (stage, prior therapies, etc.)

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Has the patient ever received treatments known to be associated with cardiac or pulmonary toxicity? Check all that apply.

- ☐ Bleomycin
- ☐ Carmustine
- ☐ Cyclophosphamide
- ☐ Everolimus
- ☐ Gemcitabine
- ☐ Anthracyclines
- ☐ Antibody-drug conjugates
- ☐ Anti-CD38 antibodies (e.g. daratumumab)
- ☐ Checkpoint inhibitors
- ☐ Immunotherapy
- ☐ Monoclonal antibodies
- ☐ Platinum agents
- ☐ Taxanes
- ☐ Tyrosine kinase inhibitors (TKIs)
- ☐ Radiation involving a lung field
- ☐ Other
- ☐ Unknown
- ☐ None

Please list specific drugs

_____

Has the patient experienced a current or past (ever) iRAE CTCAE grade 3 or above? Check all that apply.

- ☐ Pruritis
- ☐ Rash
- ☐ Vitiligo
- ☐ Myositis
- ☐ Myasthenia gravis
- ☐ Arthralgia
- ☐ Arthritis
- ☐ Pneumonitis
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Diarrhea
- ☐ Colitis
- ☐ Enteritis
- ☐ Hepatitis
- ☐ Other
- ☐ None
- ☐ Unknown

Please specify what other iRAE CTCAE grade 3 or above.

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Was there ever evidence of an immune-related adverse event (irAE) affecting the lungs or heart? (pneumonitis, myocarditis)	◯ No ◯ Possible ◯ Likely ◯ Definite
Please specify Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Please specify other past treatments with potential cardiac or pulmonary toxicity.	_____
If the patient had potentially lung-toxic therapy in the past, please provide further details. For example, how long ago the treatment was, whether there was overt lung toxicity at the time of treatment, etc. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____

Free text entry (optional)

Comments Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____

Respondent Details

Almost done! This page collects some information about you, so that we can understand a bit more about who is caring for cancer patients with COVID-19.

Once you've filled out this form, you must click SUBMIT to save and continue to the survey queue. From there, you may return later and edit your responses and create follow-up forms, using the survey queue link. If you wish to navigate to another form without saving, use the survey queue button at the top right corner.

Please do not record any PHI in this survey, including dates! This registry is not exempted from ordinary HIPAA requirements.

Timestamp for the fourth form

_____

A bit about you

Are you the primary managing hematologist/oncologist?

- ◯ Yes
- ◯ No

What is your practice setting? Check all that apply.

- ☐ Community Practice
- ☐ Community Hospital
- ☐ University Hospital
- ☐ NCI designated Comprehensive Cancer Center
- ☐ Other Cancer Centers
- ☐ Other Tertiary Center

What is your role in relationship to the patient?

- ◯ Advanced practice practitioner who regularly sees patient
- ◯ Nurse who regularly sees patient
- ◯ Hematology/oncology fellow who regularly sees patient
- ◯ Triage personnel
- ◯ Hospitalist
- ◯ Intensivist
- ◯ Designee of a CCC19 participating institution
- ◯ Other

Please specify

_____

Thank you very much for filling out this short survey. Due to IRB restrictions, we are not able to collect further personal details from you at this time. You may learn more about CCC19 by visiting the CCC19 website (clicking this link will open a new window).

Please leave any general comments here, including what if anything we can do to make the survey better.

_____

Follow-up

This form is for recording follow-up details, relative to the date of COVID-19 diagnosis. It is repeatable.

Once you've filled out this form, you must click SUBMIT to save and return to the survey queue. Once you've completed the first follow-up form, you'll see a button in your survey queue to "add a new form"; you can also edit responses to any of the follow-up forms, as required.

Please do not record any PHI in this survey, including dates! This registry is not exempted from ordinary HIPAA requirements.

Timestamp for the fifth form

_____

How far out from initial COVID-19 diagnosis are you making this report?

◯ Approximately 30 days after COVID-19 diagnosis
◯ Approximately 90 days after COVID-19 diagnosis
◯ All other time intervals

Please specify, in weeks, how much time has elapsed since initial COVID-19 diagnosis.

_____

What is prompting this follow-up report?

◯ Hospitalization
◯ Major change in clinical status other than hospitalization
◯ Death
◯ Other

Please specify

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

COVID-19 follow-up details -- required

Current COVID-19 status

Fully recovered means that the patient has returned to their baseline functional status and repeat SARS-CoV-2 testing, if obtained, is negative. If they are on medications to treat sequelae or have functional compromise (e.g., impaired pulmonary function) but are not considered to have active infection, they should be considered to have recovered with complications.

◯ Fully recovered
◯ Recovered with complications
◯ Ongoing infection
◯ Died
◯ Unknown

Please provide additional details about the proximal cause of death.

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

WHO Ordinal Scale for Clinical Improvement

Please note that this scale is somewhat redundant to other questions here, but will help us to validate the scale as a reliable tool for determining disease severity at fixed time-based endpoints.

- ◯ Ambulatory (Not hospitalized) with no limitation of activities
- ◯ Ambulatory (Not hospitalized) with limitation of activities
- ◯ Hospitalized, no oxygen therapy
- ◯ Hospitalized, requiring oxygen by mask or nasal prongs
- ◯ Hospitalized, requiring non-invasive ventilation or high-flow oxygen
- ◯ Hospitalized, requiring intubation and mechanical ventilation
- ◯ Hospitalized, requiring ventilation + additional organ support - pressors, RRT, and/or ECMO
- ◯ Other - patient does not fit into any of these categories
- ◯ Unknown

Please briefly explain why the patient does not fit into any of the categories.

_____

Current clinical status

- ◯ Outpatient - No symptoms
- ◯ Outpatient - Mild symptoms
- ◯ Outpatient - Moderate symptoms
- ◯ Outpatient - Severe symptoms
- ◯ Inpatient - Near Recovery
- ◯ Inpatient - Moderately ill
- ◯ Inpatient - Severely ill
- ◯ Critical (ICU) - Severely ill, not requiring ventilator support
- ◯ Critical (ICU) - Severely ill, intubated
- ◯ Other
- ◯ Unknown

Please specify

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Worst severity of COVID-19 complications.

This answer should capture the worst severity from the time of diagnosis to the time of this follow-up report.

- ◯ None (patient was asymptomatic)
- ◯ Mild complications (mimimal symptoms from complications)
- ◯ Moderate complications (moderate symptoms from complications)
- ◯ Serious complications (symptoms substantially impact the patient's functional status or disabling physical functioning)
- ◯ Other
- ◯ Unknown

Severity of COVID-19 complications at the time of this follow-up report. Check all that apply.

- ☐ No complications
- ☐ Mild complications (mimimal symptoms from complications)
- ☐ Moderate complications (moderate symptoms from complications)
- ☐ Serious complications (symptoms substantially impact the patient's functional status or disabling physical functioning)
- ☐ Other
- ☐ Unknown

Please specify

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

COVID-19 Effect on Cancer Treatment

Was the patient's cancer treatment plan modified as a result of COVID-19?

- ◯ No
- ◯ Yes
- ◯ Unknown

Please provide additional details.

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Cancer status at the time of this follow-up report. If the patient has multiple primaries, please report on the cancer that was most recently treated.

- ◯ Remission/NED
- ◯ Active disease, responding to treatment
- ◯ Active disease, stable
- ◯ Active disease, progressing
- ◯ Active disease, status unknown or not yet assessed
- ◯ Unknown

COVID-19 follow-up details -- optional

The following sections contain questions that will help us more fully understand the disease course of COVID-19. Most but not all of these questions are optional.

Since you last reported on this patient, were they transitioned to hospice?

- ◯ No
- ◯ Yes
- ◯ Unknown

Please specify why the patient was transitioned to hospice.

_____

Since you last reported on this patient, were they admitted to the hospital?

- ◯ No
- ◯ Yes - admitted to floor for the duration of the illness
- ◯ Yes - admitted to floor and then transferred to the ICU
- ◯ Yes - admitted directly to the ICU
- ◯ Unknown

Was the admission related to COVID-19 or complications of COVID-19?

- ◯ Definitely related
- ◯ Possibly related
- ◯ Unrelated
- ◯ Unknown

If known, how long was the length of stay, in days?

_____

If known, how long was the length of stay prior to transfer to the ICU, in days?

_____

If known, how long was the ICU length of stay, in days?

_____

What is the patient's current location?

◯ Outpatient - follow up
◯ ER - Follow up
◯ Hospitalized (non-ICU) - new admit
◯ Hospitalized (non-ICU) - continued
◯ ICU - new admit
◯ ICU - continued
◯ None - patient is deceased
◯ Unknown

Approximately how many days elapsed between COVID-19 diagnosis and death?

If this information is unknown to you, please enter 9999 here.

_____

Please provide additional details about the proximal cause of death.

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Additional Medical Events

Please report any new complications or medical events that have arisen since completing the most recent form, whether or not they are clearly attributable to COVID-19 or another cause.

Systemic events during the follow-up period. Check all that apply. If there were no additional systemic events, please check "No additional events".

☐ Bleeding
☐ Disseminated intravascular coagulation (DIC)
☐ Multiorgan failure
☐ Sepsis
☐ Other
☐ No additional systemic events
☐ Unknown

Please specify the type of bleeding. Check all that apply.

☐ Major bleeding (requiring multiple RBCs transfusions or ICU admit)
☐ Non-major but clinically relevant bleed
☐ Minor bleed (without transfusion need)
☐ CNS hemorrhage, extensive
☐ CNS hemorrhage, limited
☐ Other
☐ Unknown

Please specify further details about bleeding.

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Please provide further details about DIC, including clinical manifestations.

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

_____

Please specify other systemic events.

Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.

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Did the patient require supplemental O2 during the follow-up period?	◯ No ◯ Yes ◯ Unknown
Pulmonary events during the follow-up period. Check all that apply. If there were no additional pulmonary events, please check "No additional events".	☐ Respiratory failure ☐ Pneumonitis ☐ Acute respiratory distress syndrome (ARDS) ☐ Pulmonary embolism ☐ Pleural effusion ☐ Empyema ☐ Other ☐ No additional pulmonary events ☐ Unknown
Which of the following supplemental O2 interventions did the patient require? Select the most invasive intervention required during the follow-up period.	◯ Nasal cannula or face mask with standard O2 ◯ High-flow nasal cannula or blow-by ◯ Non-rebreather ◯ CPAP ◯ BiPAP ◯ Intubation ◯ Unknown
Were the Berlin criteria formally assessed?	◯ No ◯ Yes ◯ Unknown/Unsure
Berlin criteria. The Berlin criteria are based on a decreased PaO2/FiO2 ratio: -mild ARDS: 201 - 300 mmHg (≤ 39.9 kPa) -moderate ARDS: 101 - 200 mmHg (≤ 26.6 kPa) -severe ARDS: ≤ 100 mmHg (≤ 13.3 kPa) Note that the Berlin definition requires a minimum positive end expiratory pressure (PEEP) of 5 cmH2O for consideration of the PaO2/FiO2 ratio. This degree of PEEP may be delivered noninvasively with CPAP to diagnose mild ARDS.	◯ Mild ◯ Moderate ◯ Severe ◯ Unknown
Please specify other pulmonary events. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____

Cardiovascular events during the follow-up period. Check all that apply. If there were no additional cardiovascular events, please check "No additional events".	☐ Hypotension ☐ Myocardial infarction ☐ Other cardiac ischemia ☐ Atrial fibrillation ☐ Ventricular fibrillation ☐ Other cardiac arrhythmia ☐ Cardiomyopathy ☐ Congestive heart failure (CHF) ☐ Pulmonary embolism (PE) ☐ Deep venous thrombosis (DVT) ☐ Superficial venous thrombosis (SVT) ☐ Cerebrovascular accident (CVA; stroke) ☐ Thrombosis, NOS ☐ Other ☐ No additional cardiovascular events ☐ Unknown
Did the patient require pressors?	◯ No ◯ Yes ◯ Unknown
Please specify other cardiac events. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Gastrointestinal events during the follow-up period. Check all that apply. If there were no additional GI events, please check "No additional events".	☐ Acute hepatic injury ☐ Ascites ☐ Bowel obstruction ☐ Bowel perforation ☐ Ileus ☐ Peritonitis ☐ Other ☐ No additional gastrointestinal events ☐ Unknown
Please specify other GI events. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Other events during the follow-up period. Check all that apply. If there were no additional other events, please check "No additional events".	☐ Acute kidney injury ☐ Seizures ☐ Gangrene ☐ Thrombosis, NOS ☐ Other ☐ No additional events ☐ Unknown
Please specify other events. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____

COVID-19 Additional Treatment

Did the patient receive any additional treatments for COVID-19 or its sequelae?	◯ No ◯ Yes ◯ Unknown
Additional treatment comments, e.g. specific doses. Please provide further information here. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Additional COVID-19 treatment. Check all that apply.	☐ Chloroquine ☐ Hydroxychloroquine (Plaquenil) ☐ Anti-virals ☐ Atazanavir ☐ Lopinavir/Ritonavir ☐ Oseltamivir (Tamiflu) ☐ Remdesivir ☐ Azithromycin (Zithromax/Z-Pak) ☐ Systemic corticosteroids (will prompt for additional details) ☐ Statins ☐ Tocilizumab ☐ Baricitinib ☐ Other interleukin inhibitors (will prompt for additional details) ☐ JAK inhibitors (will prompt for additional details) ☐ TNF alpha inhibitors (will prompt for additional details) ☐ Plasma from recovered individuals (convalescent plasma) ☐ Anticoagulation ☐ Aspirin ☐ Antiplatelet agents other than aspirin ☐ Extracorporeal membrane oxygenation (ECMO) ☐ Continuous renal replacement therapy (CRRT) ☐ Other ☐ Unknown ☐ None ☐ DEPRECATED
Steroid type. Check all that apply.	☐ Dexamethasone (Decadron) ☐ Hydrocortisone (Cortef) ☐ Methylprednisolone (Solumedrol) ☐ Prednisolone ☐ Prednisone
Steroid dosing, in prednisone dose equivalents Note: 3 mg of dexamethasone is equivalent to 20 mg of prednisone, so any dose of dexamethasone of more than 3 mg/day (21 mg/week) would be equivalant to more than 20 mg of prednisone/day.	◯ 20 mg/day or below [low dose] ◯ 10 mg/day or below [low dose] ◯ More than 10 mg/day up to 20 mg/day ◯ More than 20 mg/day but less than 1mg/kg/day ◯ Equal to or greater than 1 mg/kg/day ◯ Unknown
Please provide more details: prednisone dose equivalents (e.g., 1 mg/kg) and duration of steroid therapy. Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____

Aspirin dosing	◯ Low dose (less than 200 mg/day) ◯ Full dose ◯ Unknown
Which anticoagulants were used? Check all that apply.	☐ Vitamin K antagonists (e.g., warfarin) ☐ Low-molecular weight heparin (e.g., enoxaparin [Lovenox]) ☐ Unfractionated heparin ☐ Direct thrombin inhibitors (e.g., argatroban, dabigatran [Pradaxa]) ☐ Direct factor Xa inhibitors (e.g., apixaban [Eliquis], rivaroxaban [Xarelto]) ☐ Fondaparinux ☐ Unknown ☐ Other
Please specify Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
What was the purpose of the anticoagulant treatment? Check all that apply.	☐ Prophylactic use (without the presence of a VTE either as an inpatient or outpatient) ☐ Therapeutic use (for known VTE or ATE history) ☐ Therapeutic use (for known VTE diagnosis) ☐ Therapeutic use (for known ATE diagnosis) ☐ Therapeutic use in the absence of any thrombosis (e.g., for prevention of stroke in atrial fibrillation) ☐ For DIC during hospitalization ☐ Unknown ☐ Other
Please specify Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____
Interleukin inhibitor treatment other than tocilizumab. Check all that apply.	☐ anakinra ☐ basiliximab ☐ briakinumab ☐ brodalumab ☐ canakinumab ☐ daclizumab ☐ guselkumab ☐ ixekizumab ☐ rilonacept ☐ risankizumab ☐ sarilumab ☐ secukinumab ☐ siltuximab ☐ sirukumab ☐ tildrakizumab ☐ DEPRECATED ☐ ustekinumab

JAK inhibitor treatment. Check all that apply.	☐ Ruxolitinib (Jakafi) ☐ Tofacitinib (Xeljanz) ☐ Oclacitinib ☐ Baricitinib ☐ Peficitinib ☐ Fedratinib (Inrebic) ☐ Upadacitinib
Tumor necrosis factor alpha (TNF-α) inhibitor treatment. Check all that apply.	☐ Adalimumab ☐ Afelimomab ☐ Certolizumab pegol ☐ Etanercept ☐ Golimumab ☐ Infliximab ☐ Opinercept
Was any of the additional COVID-19 treatment given as part of a clinical trial?	◯ No ◯ Yes ◯ Unknown

COVID-19 clinical trial treatment. Check all that apply. If you do not know which drug(s) were given on clinical trial, please check "Unknown". If you are not able to disclose drug names due to institutional restrictions, please check "Other".	☐ Chloroquine ☐ Hydroxychloroquine (Plaquenil) ☐ Anti-virals ☐ Atazanavir ☐ Lopinavir/Ritonavir ☐ Oseltamivir (Tamiflu) ☐ Remdesivir ☐ Azithromycin (Zithromax/Z-Pak) ☐ Systemic corticosteroids ☐ Statins ☐ anakinra ☐ Baricitinib ☐ basiliximab ☐ briakinumab ☐ brodalumab ☐ canakinumab ☐ daclizumab ☐ guselkumab ☐ ixekizumab ☐ rilonacept ☐ risankizumab ☐ sarilumab ☐ secukinumab ☐ siltuximab ☐ sirukumab ☐ tildrakizumab ☐ tocilizumab ☐ ustekinumab ☐ adalimumab ☐ afelimomab ☐ certolizumab pegol ☐ etanercept ☐ golimumab ☐ infliximab ☐ opinercept ☐ Plasma from recovered individuals (convalescent plasma) ☐ Plasma from recovered individuals (convalescent plasma) ☐ Other ☐ Unknown
Please specify. (Note: some institutions have restrictions on sharing of this information, please check with your institutional official if you have any questions.) Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____

Thank you for completing this form. If you have additional updates in the future, please use the link from the Survey Queue to return to the survey and add a new instance of the form.

Comments Do not record any PHI in this field. As a reminder, this includes all elements of dates other than year.	_____

Manual Exclude

Field to manually exclude records identified as needing exclusion (e.g., false positive PCR)	◯ True ◯ False

Why was patient manually excluded?

_____