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

Please identify the participating institution.

- ◯ Albert Einstein Cancer Center
- ◯ Aurora Health Care
- ◯ Baptist Healthcare System
- ◯ Baylor College of Medicine
- ◯ Beth Israel Deaconess Medical Center (BIDMC)
- ◯ Brown University
- ◯ Cancer Treatment Centers of America (CTCA)
- ◯ Centre Hospitalier de l'Université de Montréal (CHUM)
- ◯ City of Hope
- ◯ Cleveland Clinic
- ◯ Columbia University/New York Presbyterian
- ◯ 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
- ◯ Gundersen Health System
- ◯ Hartford HealthCare Cancer Institute
- ◯ Houston Methodist Cancer Center
- ◯ Huntsman Cancer Institute
- ◯ Inova Schar Cancer Institute
- ◯ Intermountain Healthcare
- ◯ Segal Cancer Centre, Jewish General Hospital, McGill University
- ◯ Johns Hopkins University
- ◯ Kaiser Permanente Northwest
- ◯ Karmanos Cancer Institute
- ◯ Loma Linda University Cancer Center
- ◯ Loyola University Medical Center
- ◯ LSU Health Sciences Center
- ◯ 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
- ◯ Memorial Sloan-Kettering Cancer Center (MSKCC)
- ◯ Mercy
- ◯ Missouri Baptist Cancer Center
- ◯ Moffitt Cancer Center
- ◯ Mount Auburn Hospital
- ◯ Mount Carmel Health System
- ◯ Mount Sinai/Tisch Cancer Institute
- ◯ Northwell Health
- ◯ Northwestern University/Lurie Cancer Center
- ◯ NYU Langone Health/Perlmutter Cancer Center
- ◯ Oregon Health & Sciences University/Knight Cancer Institute (OHSU)
- ◯ Penn State Cancer Institute
- ◯ Roswell Park Comprehensive Cancer Center
- ◯ Rush University Medical Center
- ◯ Rutgers Cancer Institute of New Jersey
- ◯ SSM Health Cancer Care
- ◯ Stamford Hospital
- ◯ Stanford University
- ◯ St. Elizabeth Healthcare
- ◯ The Ohio State University
- ◯ ThedaCare Cancer Care
- ◯ Thompson Cancer Survival 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 Maryland
◯ University of Miami/Sylvester Comprehensive Cancer Center
◯ University of Michigan/Rogel Cancer Center
◯ University of Minnesota
◯ 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
◯ Vanderbilt University Medical Center/Vanderbilt-Ingram Cancer Center
◯ Virtua Health
◯ Wake Forest Baptist Comprehensive Cancer Center
◯ Washington University in St. Louis/Siteman Cancer Center
◯ Weill Cornell Medicine/Meyer Cancer Center
◯ WellSpan Health
◯ West Cancer Center
◯ Willis-Knighton Cancer Center
◯ Yale New Haven Health/Smilow Cancer Hospital
◯ TEST

Are you a healthcare provider or entering data on a healthcare provider's behalf?

◯ Yes
◯ No

We're sorry, but the survey is currently open only to healthcare professionals or those entering data on their behalf. If you are a patient or caregiver looking to enter data on yourself or someone you know, please know that we are currently working on strategies to reach out to you. Thank you for your patience!
Please click the button 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
◯ 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 history

COVID-19 initial course of illness

Cancer details

Respondent details

Follow-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 _____

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.

_____

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

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

- ◯ 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
- ◯ 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	_____
Patient height, please specify units. If you know BMI, please skip this field and enter it below.	_____
Patient weight, please specify units. If you know BMI, please skip this field and enter it below.	_____
Patient body mass index (BMI) in kg/m2	_____
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	_____

Concomitant medications being taken at time of presentation. Check all that apply.

☐ 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

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

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 (LMWH)
☐ Unfractionated heparin
☐ Direct thrombin inhibitors (e.g., argatroban)
☐ Direct factor Xa inhibitors (e.g., apixaban)
☐ Fondaparinux
☐ Unknown
☐ Other

Why were anticoagulants being used?

◯ Prophylaxis
◯ Therapeutic dosing
◯ Unknown

Please specify

_____

Please specify

_____

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

_____

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.

_____

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
- ☐ Pulmonary embolism
- ☐ Radiation pneumonitis
- ☐ ICI pneumonitis
- ☐ Cardiac disease, NOS
- ☐ Hypertension (HTN)
- ☐ Coronary artery disease (CAD)
- ☐ Congestive heart failure (CHF)
- ☐ Cardiac arrhythmia, NOS
- ☐ Atrial fibrillation
- ☐ Peripheral vascular disease (PVD)
- ☐ History of cerebrovascular accident (CVA; stroke)
- ☐ 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
- ☐ Alcoholism
- ☐ Diabetes
- ☐ 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 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

_____

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.

_____

Free text entry (optional)

Comments

_____

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?	◯ 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

Diagnostic Information

Which symptoms and/or signs were present upon initial presentation? Check all that apply.	☐ Fatigue/Malaise ☐ Fever ☐ Cough ☐ Productive cough (with sputum) ☐ SOB ☐ Myalgias ☐ Arthralgias ☐ Sore throat ☐ Headache ☐ 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.	_____
Was the patient tested as part of a pre-treatment or pre-procedure screening program?	◯ No ◯ Yes ◯ Unknown
COVID-19 diagnosis	◯ 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.	_____
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.	_____
Additional comments about COVID-19 symptoms and diagnosis.	_____

Initial Severity and Course of Illness

Initial severity of COVID-19	◯ Mild (no hospitalization required) ◯ Moderate (hospitalization indicated) ◯ Severe (ICU admission indicated) ◯ Unknown
Was the patient ever hospitalized during their course of illness?	◯ 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
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 - 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.	_____

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.	_____
How definite was the DIC diagnosis?	◯ Definite ◯ Suspected ◯ Unknown
Which of the following were used to treat the DIC?	◯ Plasma (FFP) ◯ Cryoprecipitate ◯ Unknown ◯ Other ◯ None
Please provide further details about DIC, including clinical manifestations.	_____
Please specify other systemic complications.	_____
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".	☐ Respiratory failure ☐ Pneumonitis ☐ 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 with standard O2 ◯ High-flow nasal cannula ◯ 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.

_____

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.

_____

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.

_____

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.	_____

Clinical Status

Current COVID-19 status	◯ Fully recovered ◯ Recovered with complications ◯ Ongoing infection ◯ Died
Final COVID-19 status	◯ Fully recovered ◯ Recovered with complications ◯ Died
Please provide additional details about the proximal cause of death.	_____
Approximately how many days elapsed between COVID-19 diagnosis and death?	_____
Current clinical status	◯ 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	_____
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.	◯ 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

_____

Severity of COVID-19 complications. Check all that apply.

- ☐ 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

_____

Worst severity of COVID-19 complications. Check all that apply.

- ☐ 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

_____

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.

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.

_____

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

_____

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 ☐ Lopinavir/Ritonavir ☐ Oseltamivir (Tamiflu) ☐ Remdesivir ☐ Azithromycin (Zithromax/Z-Pak) ☐ Corticosteroids (will prompt for additional details) ☐ Statins ☐ Tocilizumab ☐ Other interleukin inhibitors (will prompt for additional details) ☐ TNF alpha inhibitors (will prompt for additional details) ☐ Plasma from recovered individuals (convalescent plasma) ☐ Plasma from recovered individuals (convalescent plasma) ☐ Anticoagulation ☐ Aspirin ☐ Antiplatelet agents other than aspirin ☐ Other ☐ Unknown ☐ None
Aspirin dosing	◯ Low dose (less than 200 mg/day) ◯ Full dose ◯ Unknown
Steroid dosing, in prednisone dose equivalents	◯ 20 mg/day or below [low dose] ◯ 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.	_____
Interleukin inhibitor treatment. Check all that apply.	☐ anakinra ☐ basiliximab ☐ briakinumab ☐ brodalumab ☐ canakinumab ☐ daclizumab ☐ guselkumab ☐ ixekizumab ☐ rilonacept ☐ risankizumab ☐ sarilumab ☐ secukinumab ☐ siltuximab ☐ sirukumab ☐ tildrakizumab ☐ tocilizumab ☐ ustekinumab

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) ☐ Therapeutic use (for known VTE or ATE history) ☐ Therapeutic use (for known VTE diagnosis) ☐ Therapeutic use (for known ATE diagnosis) ☐ For DIC during hospitalization ☐ Unknown ☐ Other ☐ None (patient did not receive any anticoagulants)
Please specify	_____
Which anticoagulants were used? Check all that apply.	☐ Vitamin K antagonists (e.g., warfarin) ☐ Low-molecular weight heparin (LMWH) ☐ Unfractionated heparin ☐ Direct thrombin inhibitors (e.g., argatroban) ☐ Direct factor Xa inhibitors (e.g., apixaban) ☐ Fondaparinux ☐ Unknown ☐ Other
Please specify	_____
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 ☐ Lopinavir/Ritonavir ☐ Oseltamivir (Tamiflu) ☐ Remdesivir ☐ Azithromycin (Zithromax/Z-Pak) ☐ Corticosteroids ☐ Statins ☐ anakinra ☐ 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.)	_____
Additional COVID-19 treatment comments, e.g. specific doses. Please provide further information here.	_____
Did the patient receive any PRBC transfusions?	◯ No ◯ Yes ◯ Unknown

Free text entry (optional)

Comments

_____

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 Sarcoma (incl. Ewing and osteosarcoma)
- ◯ Brain (CNS) Cancer
- ◯ Breast Cancer
- ◯ NET or Carcinoid
- ◯ Cervical Cancer
- ◯ Colon Cancer
- ◯ Colon/Rectum Cancer
- ◯ Esophagus Cancer
- ◯ Ewing Sarcoma
- ◯ Fallopian Tube Cancer
- ◯ Gallbladder Cancer
- ◯ Germ Cell Tumor
- ◯ GIST
- ◯ Head and Neck Cancer
- ◯ Mesothelioma
- ◯ Ill Defined/Cancer of Unknown Primary
- ◯ Liver Cancer (HCC)
- ◯ Lung Cancer, NOS
- ◯ Melanoma
- ◯ Merkel Cell
- ◯ Nasopharyngeal Carcinoma
- ◯ Neuroblastoma
- ◯ 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)
- ◯ 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

Please specify

_____

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?

- ◯ 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 Sarcoma (incl. Ewing and osteosarcoma)
- ◯ Brain (CNS) Cancer
- ◯ Breast Cancer
- ◯ NET or Carcinoid
- ◯ Cervical Cancer
- ◯ Colon Cancer
- ◯ Colon/Rectum Cancer
- ◯ Esophagus Cancer
- ◯ Ewing Sarcoma
- ◯ Fallopian Tube Cancer
- ◯ Gallbladder Cancer
- ◯ Germ Cell Tumor
- ◯ GIST
- ◯ Head and Neck Cancer
- ◯ Mesothelioma
- ◯ Ill Defined/Cancer of Unknown Primary
- ◯ Liver Cancer (HCC)
- ◯ Lung Cancer, NOS
- ◯ Melanoma
- ◯ Merkel Cell
- ◯ Nasopharyngeal Carcinoma
- ◯ Neuroblastoma
- ◯ 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)
- ◯ 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
Please specify	_____
Multiple malignancies - further details. Please provide further details, including whether the primary cancers were synchronous or metachronous, the types of the multiple primaries, etc.	_____
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 ◯ Unknown
Is the patient on anti-cancer treatment? That is, was the patient receiving any antineoplastic therapies 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?	◯ 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.	☐ 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.	_____
What immunotherapy?	◯ Anti-CTLA4 antibody ◯ Anti-PD-1 antibody ◯ Anti-PD-L1 antibody ◯ Combination of anti-CTLA4 and anti-PD-1 (e.g. ipilimumab & nivolumab) ◯ Other ◯ Unknown
Please specify	_____
Some targeted therapies have postulated antiviral effects. Was the patient taking any of these medications? Check all that apply.	☐ Dasatinib (Sprycel) ☐ Imatinib (Gleevec) ☐ Nilotinib (Tasigna) ☐ Other ☐ Unknown ☐ None
Please specify	_____
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	_____
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.	_____

Transplant & cellular therapy - what type of therapy?	◯ Autologous stem cell transplant ◯ MUD allogeneic SCT ◯ MRD allogeneic SCT ◯ Haplo allogeneic SCT ◯ Cord blood allogeneic SCT ◯ CAR-T cells ◯ Other ◯ Unknown
Please specify	_____
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. If you would like, please give more details here about the specific treatment(s) that the patient has been receiving.	_____
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	_____

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.

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

Please specify

_____

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.

_____

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

_____

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

_____

Was there ever evidence of an immune-related adverse event (irAE) affecting the lungs or heart? (pneumonitis, myocarditis)

- ◯ No
- ◯ Possible
- ◯ Likely
- ◯ Definite

Please specify	_____
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.	_____

Free text entry (optional)

Comments	_____

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	_____

COVID-19 follow-up details

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
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
Approximately how many days elapsed between COVID-19 diagnosis and death?	_____
Please provide additional details about the proximal cause of death.	_____

COVID-19 Additional Complications

Please report any new complications that have arisen since completing the most recent form.

Systemic complications during the follow-up period. Check all that apply. If there were no additional systemic complications, please check "No additional complications".	☐ Bleeding ☐ Disseminated intravascular coagulation (DIC) ☐ Multiorgan failure ☐ Sepsis ☐ Other ☐ No additional complications ☐ 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.	_____
Please provide further details about DIC, including clinical manifestations.	_____
Please specify other systemic complications.	_____
Did the patient require supplemental O2 during the follow-up period?	◯ No ◯ Yes ◯ Unknown

Pulmonary complications during the follow-up period. Check all that apply. If there were no additional pulmonary complications, please check "No additional complications".

- ☐ Respiratory failure
- ☐ Pneumonitis
- ☐ ARDS
- ☐ Pulmonary embolism
- ☐ Pleural effusion
- ☐ Empyema
- ☐ Other
- ☐ No additional complications
- ☐ 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 with standard O2
- ◯ High-flow nasal cannula
- ◯ 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 complications.

_____

Cardiovascular complications during the follow-up period. Check all that apply. If there were no additional cardiovascular complications, please check "No additional complications".

- ☐ 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 complications
- ☐ Unknown

Did the patient require pressors?

- ◯ No
- ◯ Yes
- ◯ Unknown

Please specify other cardiac complications.

_____

Gastrointestinal complications during the follow-up period. Check all that apply. If there were no additional GI complications, please check "No additional complications".

- ☐ Acute hepatic injury
- ☐ Ascites
- ☐ Bowel obstruction
- ☐ Bowel perforation
- ☐ Ileus
- ☐ Peritonitis
- ☐ Other
- ☐ No additional complications
- ☐ Unknown

Please specify other GI complications.

_____

Other complications during the follow-up period. Check all that apply. If there were no additional other complications, please check "No additional complications".

- ☐ Acute kidney injury
- ☐ Seizures
- ☐ Gangrene
- ☐ Thrombosis, NOS
- ☐ Other
- ☐ No additional complications
- ☐ Unknown

Please specify other complications.

_____

COVID-19 Additional Treatment

Did the patient receive any additional treatments for COVID-19 or its sequelae?

- ◯ No
- ◯ Yes
- ◯ Unknown

Additional COVID-19 treatment. Check all that apply.	☐ Chloroquine ☐ Hydroxychloroquine (Plaquenil) ☐ Anti-virals ☐ Lopinavir/Ritonavir ☐ Oseltamivir (Tamiflu) ☐ Remdesivir ☐ Azithromycin (Zithromax/Z-Pak) ☐ Corticosteroids (will prompt for additional details) ☐ Statins ☐ Tocilizumab ☐ Other interleukin inhibitors (will prompt for additional details) ☐ TNF alpha inhibitors (will prompt for additional details) ☐ Plasma from recovered individuals (convalescent plasma) ☐ Plasma from recovered individuals (convalescent plasma) ☐ Anticoagulation ☐ Aspirin ☐ Antiplatelet agents other than aspirin ☐ Other ☐ Unknown
Steroid dosing, in prednisone dose equivalents	◯ 20 mg/day or below [low dose] ◯ 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.	_____
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 (LMWH) ☐ Unfractionated heparin ☐ Direct thrombin inhibitors (e.g., argatroban) ☐ Direct factor Xa inhibitors (e.g., apixaban) ☐ Fondaparinux ☐ Unknown ☐ Other
Please specify	_____
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) ☐ For DIC during hospitalization ☐ Unknown ☐ Other

Please specify	_____
Interleukin inhibitor treatment. Check all that apply.	☐ anakinra ☐ basiliximab ☐ briakinumab ☐ brodalumab ☐ canakinumab ☐ daclizumab ☐ guselkumab ☐ ixekizumab ☐ rilonacept ☐ risankizumab ☐ sarilumab ☐ secukinumab ☐ siltuximab ☐ sirukumab ☐ tildrakizumab ☐ tocilizumab ☐ ustekinumab
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 ☐ Lopinavir/Ritonavir ☐ Oseltamivir (Tamiflu) ☐ Remdesivir ☐ Azithromycin (Zithromax/Z-Pak) ☐ Corticosteroids ☐ Statins ☐ anakinra ☐ 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.)	_____
Additional treatment comments, e.g. specific doses. Please provide further information here.	_____

Clinical Outcomes

Current COVID-19 status	◯ Fully recovered ◯ Recovered with complications ◯ Ongoing infection ◯ Died

Current clinical status	◯ 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	_____
Severity of COVID-19 complications. Check all that apply.	☐ 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	_____

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.	_____
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 ◯ Unknown

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.