



**World Health  
Organization**

PARTICIPANT IDENTIFICATION #: [ ][ ][ ][ ][ ]--- [ ][ ][ ][ ]

## ISARIC CORE CASE REPORT FORM

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## presentation

Participant Identification Number (PIN):	
<b>INCLUSION CRITERIA</b>	
Does the patient have reported/ measured fever (axillary temperature >38.5°C [101.3 °F])?	<input type="radio"/> Yes <input type="radio"/> No
Does the patient have evidence of acute brain pathology (e.g., altered mental status, new onset seizures, or new neurological deficit either diffuse or localized to the brain).	<input type="radio"/> Yes <input type="radio"/> No
Participant is enrolled in the icddr,b-IEDCR NiV surveillance programme.	<input type="radio"/> Yes <input type="radio"/> No
Participant (or their legal representative) has provided consent to participate in this study.	<input type="radio"/> Yes <input type="radio"/> No
<b>EXCLUSION CRITERIA</b>	
Does the patient have a clear alternative non-infectious diagnosis (either clinical or laboratory/imaging confirmed diagnosis) that explains the acute presentation	<input type="radio"/> Yes <input type="radio"/> No
<b>ONSET &amp; ADMISSION</b>	
Date of enrolment / start of data collection	[ _D_] [ _D_] [ / ] [ _M_] [ _M_] [ / ] [ _2_] [ _0_] [ _Y_] [ _Y_]
Onset date of first / earliest symptom	[ _D_] [ _D_] [ / ] [ _M_] [ _M_] [ / ] [ _2_] [ _0_] [ _Y_] [ _Y_]
First symptom (select multiple if occurred at same time)	_____
Select First symptom (select multiple if occurred at same time)	_____
Specify other First symptom (select multiple if occurred at same time)	_____
<b>RE-ADMISSION AND PREVIOUS PIN</b>	
Was the patient admitted previously or transferred from any other facility during this illness episode?	<input type="radio"/> YES-admitted previously to this facility and discharged <input type="radio"/> YES-admitted to other facility and discharged <input type="radio"/> YES-admitted to another facility, then transferred to this facility <input type="radio"/> No <input type="radio"/> Unknown
Date of earliest admission for this infection	[ _D_] [ _D_] [ / ] [ _M_] [ _M_] [ / ] [ _2_] [ _0_] [ _Y_] [ _Y_]
<b>DEMOGRAPHICS</b>	
Sex at Birth	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Not specified/Unknown
Age	_____
Age units	<input type="radio"/> Years <input type="radio"/> Months <input type="radio"/> Days
Height (cm)	_____
Weight (kg)	_____
Employed as a healthcare worker	<input type="radio"/> Yes, patient facing <input type="radio"/> Yes, laboratory <input type="radio"/> Yes, no patients/laboratory <input type="radio"/> No <input type="radio"/> Unknown

Primary location of occupation	<input type="radio"/> Home-working or unemployed <input type="radio"/> <input type="radio"/> Indoors-office/health/education/hospitality/business/homes <input type="radio"/> <input type="radio"/> Indoors-factory <input type="radio"/> Outdoors-animal contact (vet, animal farmer, abattoir worker) <input type="radio"/> <input type="radio"/> Outdoors-agriculture/forestry/fisheries <input type="radio"/> <input type="radio"/> Outdoors-DPS collector <input type="radio"/> Outdoors-construction/industrial/mining <input type="radio"/> <input type="radio"/> Armed Forces <input type="radio"/> Student <input type="radio"/> Other <input type="radio"/> Unknown
Specify other primary location of occupation	_____
Patient's city of residence	<input type="radio"/> Same as health care facility <input type="radio"/> Different from health care facility <input type="radio"/> <input type="radio"/> Unknown
Specify region (sub-district) of residence	_____
<b>EXPOSURE HISTORY IN PREVIOUS 14 DAYS</b>	
Drinking raw date palm sap (DPS)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
<b>EXPOSURE HISTORY</b>	
Drinking fermented DPS	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Eating bat/bird eaten fruits	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Close contact with patient with similar illness	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Contact with bat/s	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Contact with pig/s	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Contact with domestic animal/s	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Other type of exposure history	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Specify other type of exposure.	_____
<b>PREGNANCY</b>	
Pregnant	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Gestational weeks assessment (weeks)	_____
Post-partum (within 6 weeks of delivery)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Delivery date	[ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ]
Pregnancy outcome	<input type="radio"/> Live birth <input type="radio"/> Still birth <input type="radio"/> Termination
Gestational weeks at pregnancy outcome	_____
<b>INFANT: less than 12 months old</b>	
Gestational outcome	<input type="radio"/> Term birth (>=37wk GA) <input type="radio"/> Preterm birth (< 37wk GA) <input type="radio"/> <input type="radio"/> Unknown
Vaccinations appropriate for age/country	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
<b>CO-MORBIDITIES AND RISK FACTORS: Existing prior to presentation or admission with this current illness and is ongoing (remains an active medical condition)</b>	
Chronic cardiac disease (not hypertension)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Hypertension (physician diagnosed)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Chronic pulmonary disease (not asthma)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Asthma (physician diagnosed)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown

Chronic kidney disease	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Obesity (as defined by clinical staff)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Liver disease	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Mild liver disease	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Moderate or severe liver disease	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Chronic hepatitis B/C infection	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Asplenia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Chronic neurological disorder	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Malignant neoplasm	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Chronic hematologic disease	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Active chickenpox	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Previous Shingles (herpes zoster)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
AIDS / HIV	<input type="radio"/> YES-on ART <input type="radio"/> YES-not on ART <input type="radio"/> NO <input type="radio"/> Unknown
Diabetes Mellitus	<input type="radio"/> YES - Type 1 <input type="radio"/> YES - Type 2 <input type="radio"/> YES - Gestational <input type="radio"/> NO <input type="radio"/> Unknown
Dementia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Malnutrition	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Smoking	<input type="radio"/> Current smoker <input type="radio"/> Never smoked <input type="radio"/> Former smoker <input type="radio"/> Unknown
Other relevant comorbidity(s)	_____
Select other relevant comorbidity(s)	_____
Specify other relevant comorbidity(s)	_____
Any additional other relevant comorbidity(s) ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>Select additional other relevant comorbidity(s) 2	_____
>Specify other relevant comorbidity(s) 2	_____
>Any additional other relevant comorbidity(s) ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
->Select additional other relevant comorbidity(s) 3	_____
->Specify other relevant comorbidity(s) 3	_____
->Any additional other relevant comorbidity(s) ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>->Select additional other relevant comorbidity(s) 4	_____
>->Specify other relevant comorbidity(s) 4	_____
>->Any additional other relevant comorbidity(s) ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
->->Select additional other relevant comorbidity(s) 5	_____
->->Specify other relevant comorbidity(s) 5	_____

**ISARIC CORE CASE REPORT FORM**

<b>MEDICATION PREVIOUS 14-DAYS: include all taken within 14 days prior to this most recent admission / presentation</b>	
Steroid	_____
Steroid administration route	<input type="radio"/> Oral <input type="radio"/> Inhaled <input type="radio"/> IV <input type="radio"/> Unknown
Select steroid	↓ Beclomethasone (Beclometasone, Beconase) ↓ Betamethasone (Celestone, Betnelan) ↓ Budesonide (Pulmicort) ↓ Cortisone (Cortone) ↓ Dexamethasone (Decadron, Dexasone, Diodex) ↓ Fludrocortisone (Astonin, Florinef) ↓ Fluticasone (Flovent, Flonase) ↓ Hydrocortisone (Cortef, Solu-Cortef) ↓ Methylprednisolone (Medrol, Solu-Medrol) ↓ Mometasone (Asmanex, Elocon, Nasonex) ↓ Prednisolone (Prelone, Orapred) ↓ Prednisone (Deltasone) ↓ Triamcinolone (Kenalog, Aristocort) ↓ Other
Specify other steroid	_____
Steroid administration route	<input type="radio"/> Oral <input type="radio"/> Inhaled <input type="radio"/> IV <input type="radio"/> Unknown
Any additional steroid ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>Select additional steroid 2	↓ Beclomethasone (Beclometasone, Beconase) ↓ Betamethasone (Celestone, Betnelan) ↓ Budesonide (Pulmicort) ↓ Cortisone (Cortone) ↓ Dexamethasone (Decadron, Dexasone, Diodex) ↓ Fludrocortisone (Astonin, Florinef) ↓ Fluticasone (Flovent, Flonase) ↓ Hydrocortisone (Cortef, Solu-Cortef) ↓ Methylprednisolone (Medrol, Solu-Medrol) ↓ Mometasone (Asmanex, Elocon, Nasonex) ↓ Prednisolone (Prelone, Orapred) ↓ Prednisone (Deltasone) ↓ Triamcinolone (Kenalog, Aristocort) ↓ Other
>Specify other steroid 2	_____
>Steroid administration route 2	<input type="radio"/> Oral <input type="radio"/> Inhaled <input type="radio"/> IV <input type="radio"/> Unknown
>Any additional steroid ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
->Select additional steroid 3	↓ Beclomethasone (Beclometasone, Beconase) ↓ Betamethasone (Celestone, Betnelan) ↓ Budesonide (Pulmicort) ↓ Cortisone (Cortone) ↓ Dexamethasone (Decadron, Dexasone, Diodex) ↓ Fludrocortisone (Astonin, Florinef) ↓ Fluticasone (Flovent, Flonase) ↓ Hydrocortisone (Cortef, Solu-Cortef) ↓ Methylprednisolone (Medrol, Solu-Medrol) ↓ Mometasone (Asmanex, Elocon, Nasonex) ↓ Prednisolone (Prelone, Orapred) ↓ Prednisone (Deltasone) ↓ Triamcinolone (Kenalog, Aristocort) ↓ Other
->Specify other steroid 3	_____
->Steroid administration route 3	<input type="radio"/> Oral <input type="radio"/> Inhaled <input type="radio"/> IV <input type="radio"/> Unknown
->Any additional steroid ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>->Select additional steroid 4	↓ Beclomethasone (Beclometasone, Beconase) ↓ Betamethasone (Celestone, Betnelan) ↓ Budesonide (Pulmicort) ↓ Cortisone (Cortone) ↓ Dexamethasone (Decadron, Dexasone, Diodex) ↓ Fludrocortisone (Astonin, Florinef) ↓ Fluticasone (Flovent, Flonase) ↓ Hydrocortisone (Cortef, Solu-Cortef) ↓ Methylprednisolone (Medrol, Solu-Medrol) ↓ Mometasone (Asmanex, Elocon, Nasonex) ↓ Prednisolone (Prelone, Orapred) ↓ Prednisone (Deltasone) ↓ Triamcinolone (Kenalog, Aristocort) ↓ Other
>->Specify other steroid 4	_____
>->Steroid administration route 4	<input type="radio"/> Oral <input type="radio"/> Inhaled <input type="radio"/> IV <input type="radio"/> Unknown
>->Any additional steroid ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown

->->Select additional steroid 5	<input type="checkbox"/> Beclomethasone (Beclometasone, Beconase) <input type="checkbox"/> Betamethasone (Celestone, Betnelan) <input type="checkbox"/> Budesonide (Pulmicort) <input type="checkbox"/> Cortisone (Cortone) <input type="checkbox"/> Dexamethasone (Decadron, Dexasone, Diodex) <input type="checkbox"/> Fludrocortisone (Astonin, Florinef) <input type="checkbox"/> Fluticasone (Flovent, Flonase) <input type="checkbox"/> Hydrocortisone (Cortef, Solu-Cortef) <input type="checkbox"/> Methylprednisolone (Medrol, Solu-Medrol) <input type="checkbox"/> Mometasone (Asmanex, Elocon, Nasonex) <input type="checkbox"/> Prednisolone (Prelone, Orapred) <input type="checkbox"/> Prednisone (Deltasone) <input type="checkbox"/> Triamcinolone (Kenalog, Aristocort) <input type="checkbox"/> Other
->->Specify other steroid 5	_____
->->Steroid administration route 5	<input type="radio"/> Oral <input type="radio"/> Inhaled <input type="radio"/> IV <input type="radio"/> Unknown
Immunosuppressant agents (not steroids)	_____
Select immunosuppressant agents (not steroids)	_____
Specify other immunosuppressant agents (not steroids)	_____
Any additional immunosuppressant agents (not steroids) ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>Select additional immunosuppressant agents (not steroids) 2	_____
>Specify other immunosuppressant agents (not steroids) 2	_____
>Any additional immunosuppressant agents (not steroids) ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
->Select additional immunosuppressant agents (not steroids) 3	_____
->Specify other immunosuppressant agents (not steroids) 3	_____
->Any additional immunosuppressant agents (not steroids) ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>->Select additional immunosuppressant agents (not steroids) 4	_____
>->Specify other immunosuppressant agents (not steroids) 4	_____
>->Any additional immunosuppressant agents (not steroids) ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
->->Select additional immunosuppressant agents (not steroids) 5	_____
->->Specify other immunosuppressant agents (not steroids) 5	_____
Antibiotics	_____
Select antibiotics	_____
Specify other antibiotics	_____
Any additional antibiotics ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>Select additional antibiotics 2	_____
>Specify other antibiotics 2	_____
>Any additional antibiotics ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown

->Select additional antibiotics 3	_____
->Specify other antibiotics 3	_____
->Any additional antibiotics ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>->Select additional antibiotics 4	_____
>->Specify other antibiotics 4	_____
>->Any additional antibiotics ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
->->Select additional antibiotics 5	_____
->->Specify other antibiotics 5	_____
Antiviral	_____
Select antiviral	_____
Specify other antiviral	_____
Any additional antiviral ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>Select additional antiviral 2	_____
>Specify other antiviral 2	_____
>Any additional antiviral ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
->Select additional antiviral 3	_____
->Specify other antiviral 3	_____
->Any additional antiviral ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>->Select additional antiviral 4	_____
>->Specify other antiviral 4	_____
>->Any additional antiviral ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
->->Select additional antiviral 5	_____
->->Specify other antiviral 5	_____
Anticoagulant	_____
Select anticoagulant	_____
Specify other anticoagulant	_____
Any additional anticoagulant ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>Select additional anticoagulant 2	_____
>Specify other anticoagulant 2	_____
>Any additional anticoagulant ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
->Select additional anticoagulant 3	_____
->Specify other anticoagulant 3	_____
->Any additional anticoagulant ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>->Select additional anticoagulant 4	_____
>->Specify other anticoagulant 4	_____
>->Any additional anticoagulant ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
->->Select additional anticoagulant 5	_____

->->Specify other anticoagulant 5	_____
Intravenous fluid	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Intravenous fluid type	↓ Crystalloid ↓ Albumin ↓ Gelatin ↓ Starches ↓ Fibrinogen concentrate ↓ Other fluid
Total intravenous fluid volume in the previous 24 hours (mL)	_____
Additional intravenous fluid	<input type="radio"/> Yes <input type="radio"/> No
Intravenous fluid type	↓ Crystalloid ↓ Albumin ↓ Gelatin ↓ Starches, ↓ Fibrinogen concentrate ↓ Other fluid
Other pathogen-targeted medications	_____
Select other pathogen-targeted medications	_____
Specify other pathogen-targeted medications	_____
Any additional other pathogen-targeted medications ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>Select additional other pathogen-targeted medications 2	_____
>Specify other pathogen-targeted medications 2	_____
>Any additional other pathogen-targeted medications ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
->Select additional other pathogen-targeted medications 3	_____
->Specify other pathogen-targeted medications 3	_____
->Any additional other pathogen-targeted medications ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>->Select additional other pathogen-targeted medications 4	_____
>->Specify other pathogen-targeted medications 4	_____
>->Any additional other pathogen-targeted medications ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
->->Select additional other pathogen-targeted medications 5	_____
->->Specify other pathogen-targeted medications 5	_____
<b>VACCINATION</b>	
Vaccinated for COVID-19 (ever)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Date of most recent COVID-19 vaccine	[ _D ][ _D ][ / ][ _M ][ _M ][ / ][ 2_ ][ _0 ][ _Y ][ _Y ]
INFLUENZA	_____
Vaccinated for influenza (ever)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Date of most recent influenza vaccine	[ _D ][ _D ][ / ][ _M ][ _M ][ / ][ 2_ ][ _0 ][ _Y ][ _Y ]



Completed all vaccinations under the Expanded Programme on Immunization (EPI) (BCG, Diphtheria, Pertussis, Tetanus, Hepatitis B, Hib, PCV, OPV, MMR)	<input type="radio"/> Yes-reported <input type="radio"/> Yes - confirmed with vaccination card <input type="radio"/> No <input type="radio"/> Unknown
Varicella vaccination	<input type="radio"/> Yes-reported <input type="radio"/> Yes - confirmed with vaccination card <input type="radio"/> No <input type="radio"/> Unknown
JE vaccination	<input type="radio"/> Yes-reported <input type="radio"/> Yes - confirmed with vaccination card <input type="radio"/> No <input type="radio"/> Unknown
<b>SIGNS AND SYMPTOMS ON ADMISSION: first data, from onset of this acute illness to day of presentation or admission</b>	
Fever / chills / rigors	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Restlessness	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Fatigue / Malaise / Lethargy	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Weight loss	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Cough	<input type="radio"/> Yes, non-productive <input type="radio"/> Yes, productive <input type="radio"/> Yes, with haemoptysis <input type="radio"/> No <input type="radio"/> Unknown
Sore throat	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Runny nose (rhinorrhoea)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Wheezing	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Shortness of breath	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Lower chest wall indrawing	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Abdominal pain	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Diarrhoea	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Vomiting / Nausea	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Anorexia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Parotitis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Excessive salivation	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Orchitis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Bleeding / Haemorrhage	_____
Bleeding / Haemorrhage	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Specify bleeding / haemorrhage site(s)	<input type="checkbox"/> Skin <input type="checkbox"/> Nose <input type="checkbox"/> Gums <input type="checkbox"/> GI tract <input type="checkbox"/> Urinary tract <input type="checkbox"/> Vagina <input type="checkbox"/> Other
Jaundice	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Muscle aches / Myalgia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Joint pain / Arthralgia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Headache	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Neck stiffness	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Photophobia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Retro-orbital pain	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Seizures / Convulsions	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Type of seizure	<input type="radio"/> Focal <input type="radio"/> Generalised tonic clonic <input type="radio"/> Unknown
Altered consciousness / confusion	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown

Psychological disturbance	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Myoclonus	<input type="radio"/> Yes <input type="radio"/> No
Cerebellar signs	<input type="radio"/> Yes <input type="radio"/> No
Tremor	<input type="radio"/> Yes <input type="radio"/> No
Dystonia	<input type="radio"/> Yes <input type="radio"/> No
Specify dystonia site	<input type="checkbox"/> Right Upper Extremity <input type="checkbox"/> Right Lower Extremity <input type="checkbox"/> Left Upper Extremity <input type="checkbox"/> Left Lower Extremity <input type="checkbox"/> Face <input type="checkbox"/> Other
Specify other dystonia site	_____
Facial palsy	<input type="radio"/> Yes <input type="radio"/> No
Dysarthria	<input type="radio"/> Yes <input type="radio"/> No
Dysphasia	<input type="radio"/> Yes <input type="radio"/> No
Plantar reflex	<input type="radio"/> Equivocal <input type="radio"/> Extensor <input type="radio"/> Flexor <input type="radio"/> Absent
Deep tendon reflex	<input type="radio"/> Diminished <input type="radio"/> Exaggerated <input type="radio"/> Normal <input type="radio"/> Absent
Other neurological abnormality	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Specify other neurological abnormality	_____
Conjunctivitis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Nystagmus	<input type="radio"/> Yes <input type="radio"/> No
Ptosis	<input type="radio"/> Yes, unilateral <input type="radio"/> Yes, bilateral <input type="radio"/> No
Skin rash	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Inability to walk	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Mobility status	<input type="radio"/> Fully ambulant <input type="radio"/> Ambulant, but with some assistance <input type="radio"/> Bedridden
Other sign(s) or abnormality	_____
Select other sign(s) or abnormality	_____
Specify other sign(s) or abnormality	_____
Any additional other sign(s) or abnormality ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>Select additional other sign(s) or abnormality 2	_____
>Specify other sign(s) or abnormality 2	_____
>Any additional other sign(s) or abnormality ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
->Select additional other sign(s) or abnormality 3	_____
->Specify other sign(s) or abnormality 3	_____
->Any additional other sign(s) or abnormality ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>->Select additional other sign(s) or abnormality 4	_____
>->Specify other sign(s) or abnormality 4	_____
>->Any additional other sign(s) or abnormality ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown

->->Select additional other sign(s) or abnormality 5	_____
->->Specify other sign(s) or abnormality 5	_____

**daily**

<b>SIGNS AND SYMPTOMS: Record the value furthest from normal range between 00:00 to 24:00 on day of assessment</b>	
Enter signs and symptoms data for this date?	<input type="radio"/> Yes <input type="radio"/> No
Fever / chills / rigors	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Restlessness	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Fatigue / Malaise / Lethargy	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Weight loss	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Cough	<input type="radio"/> Yes, non-productive <input type="radio"/> Yes, productive <input type="radio"/> Yes, with haemoptysis <input type="radio"/> No <input type="radio"/> Unknown
Sore throat	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Runny nose (rhinorrhoea)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Wheezing	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Shortness of breath	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Lower chest wall indrawing	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Abdominal pain	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Diarrhoea	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Vomiting / Nausea	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Anorexia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Parotitis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Excessive salivation	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Orchitis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Bleeding / haemorrhage	_____
Bleeding / haemorrhage	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Specify bleeding / haemorrhage site(s)	<input type="checkbox"/> Skin <input type="checkbox"/> Nose <input type="checkbox"/> Gums <input type="checkbox"/> GI tract <input type="checkbox"/> Urinary tract <input type="checkbox"/> Vagina <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Jaundice	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Muscle aches / myalgia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Joint pain / arthralgia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Headache	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Neck stiffness	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Photophobia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Retro-orbital pain	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Seizures / Convulsions	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Type of seizure	<input type="radio"/> Focal <input type="radio"/> Generalised tonic clonic <input type="radio"/> Unknown
Altered consciousness / confusion	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown

Psychological disturbance	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Myoclonus	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Cerebellar signs	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Tremor	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Dystonia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Specify dystonia site	<input type="checkbox"/> Right Upper Extremity <input type="checkbox"/> Right Lower Extremity <input type="checkbox"/> Left Upper Extremity <input type="checkbox"/> Left Lower Extremity <input type="checkbox"/> Face <input type="checkbox"/> Other
Specify other dystonia site	_____
Facial palsy	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Dysarthria	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Dysphasia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Plantar reflex	<input type="radio"/> Equivocal <input type="radio"/> Extensor <input type="radio"/> Flexor <input type="radio"/> Absent <input type="radio"/> Unknown
Deep tendon reflex	<input type="radio"/> Diminished <input type="radio"/> Exaggerated <input type="radio"/> Normal <input type="radio"/> Absent <input type="radio"/> Unknown
Other neurological abnormality	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Specify other neurological abnormality	_____
Conjunctivitis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Nystagmus	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Ptosis	<input type="radio"/> Yes, unilateral <input type="radio"/> Yes, bilateral <input type="radio"/> No
Skin rash	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Inability to walk	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Mobility status	<input type="radio"/> Fully ambulant <input type="radio"/> Ambulant, but with some assistance <input type="radio"/> Bedridden
Other sign(s) or symptom(s)	_____
Select other sign(s) or symptom(s)	_____
Specify other sign(s) or symptom(s)	_____
Any additional other sign(s) or symptom(s) ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>Select additional other sign(s) or symptom(s) 2	_____
>Specify other sign(s) or symptom(s) 2	_____
>Any additional other sign(s) or symptom(s) ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
->Select additional other sign(s) or symptom(s) 3	_____
->Specify other sign(s) or symptom(s) 3	_____
->Any additional other sign(s) or symptom(s) ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>>Select additional other sign(s) or symptom(s) 4	_____
>>Specify other sign(s) or symptom(s) 4	_____
>>Any additional other sign(s) or symptom(s) ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown

->->Select additional other sign(s) or symptom(s) 5	_____
->->Specify other sign(s) or symptom(s) 5	_____
<b>VITAL SIGNS &amp; ASSESSMENTS: Record the value furthest from normal range between 00:00 to 24:00 on day of assessment.</b>	
Enter Vital Signs data for this date?	<input type="radio"/> Yes <input type="radio"/> No
Highest temperature (C)	_____
HR (beats/minute)	_____
RR (bpm)	_____
Systolic BP (mmHg)	_____
Diastolic BP (mmHg)	_____
Lowest Oxygen saturation SpO2 (%)	_____
FiO2 measured at time of lowest SpO2	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
FiO2 at time of lowest SpO2	_____
Select FiO2 at time of lowest SpO2 units	<input type="radio"/> select units <input type="radio"/> %, 21-100
Capillary refill time >2seconds	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
AVPU	<input type="radio"/> Alert <input type="radio"/> Verbal <input type="radio"/> Pain <input type="radio"/> Unresponsive
Glasgow Coma Score (GCS / 15)	_____
<b>LABORATORY RESULTS: Record the value furthest from normal range between 00:00 to 24:00 on day of assessment. In general, do not report results that have been rejected by the clinical team (e.g. haemolysed sample). Unless otherwise specified, if there are multiple measurements please report the measure furthest from the normal physiological or laboratory range between 00:00 and 24:00 hours on day of assessment. If any individual test was not performed indicate 'No' or if the result is unavailable, please leave the data field blank.</b>	
Enter Laboratory Results data for this date?	<input type="radio"/> Yes <input type="radio"/> No
Has the participant had a blood test at this visit? If additional research samples were collected during this visit, please fill in the research sampling form	<input type="radio"/> Yes <input type="radio"/> No
FBC (Full Blood Count)	<input type="radio"/> Yes <input type="radio"/> No
U&E; (Renal profile)	<input type="radio"/> Yes <input type="radio"/> No
(LFT) Liver profile	<input type="radio"/> Yes <input type="radio"/> No
Bone profile	<input type="radio"/> Yes <input type="radio"/> No
Blood glucose	<input type="radio"/> Yes <input type="radio"/> No
HIV serology (only at admission)	<input type="radio"/> Yes <input type="radio"/> No
Haemoglobin	_____
Select Haemoglobin units	<input type="radio"/> select units <input type="radio"/> g/dL <input type="radio"/> g/L <input type="radio"/> mmol/L
WBC count (10 <sup>9</sup> /L)	_____
Lymphocytes	_____

Select Lymphocytes units	<input type="radio"/> select units <input type="radio"/> 10 <sup>9</sup> /L <input type="radio"/> 10 <sup>6</sup> /L <input type="radio"/> cells/uL <input type="radio"/> 10 <sup>3</sup> /uL <input type="radio"/> %
Neutrophils	_____
Select Neutrophils units	<input type="radio"/> select units <input type="radio"/> 10 <sup>9</sup> /L <input type="radio"/> 10 <sup>6</sup> /L <input type="radio"/> cells/uL <input type="radio"/> 10 <sup>3</sup> /uL <input type="radio"/> %
Hematocrit	_____
Select Hematocrit units	<input type="radio"/> select units <input type="radio"/> % <input type="radio"/> fraction of 1 <input type="radio"/> L/L
Platelets	_____
Select Platelets units	<input type="radio"/> select units <input type="radio"/> 10 <sup>9</sup> /L <input type="radio"/> 10 <sup>6</sup> /L <input type="radio"/> 10 <sup>3</sup> /uL
Activated Partial Thromboplastin Time/APTT (sec)	_____
Prothrombin Time/PT	_____
Select Prothrombin Time/PT units	<input type="radio"/> select units <input type="radio"/> sec <input type="radio"/> Prothrombin Intl. Normalized Ratio
TQ/INR	_____
ALT/SGPT (U/L)	_____
Total Bilirubin	_____
Select Total Bilirubin units	<input type="radio"/> select units <input type="radio"/> umol/L <input type="radio"/> mg/dL
ALP (IU/L)	_____
AST/SGOT (U/L)	_____
Random glucose	_____
Select Random glucose units	<input type="radio"/> select units <input type="radio"/> mmol/L <input type="radio"/> mg/dL <input type="radio"/> g/L
Gamma Glutamyl Transferase/GGT (U/L)	_____
Urea/BUN	_____
Select Urea/BUN units	<input type="radio"/> select units <input type="radio"/> mmol/L <input type="radio"/> mg/dL
Creatinine	_____
Select Creatinine units	<input type="radio"/> select units <input type="radio"/> umol/L <input type="radio"/> mg/dL
Sodium	_____
Select Sodium units	<input type="radio"/> select units <input type="radio"/> mmol/L <input type="radio"/> mEq/L
Potassium	_____
Select Potassium units	<input type="radio"/> select units <input type="radio"/> mmol/L <input type="radio"/> mEq/L
Procalcitonin	_____
Select Procalcitonin units	<input type="radio"/> select units <input type="radio"/> ug/L <input type="radio"/> ng/mL
CRP	_____
Select CRP units	<input type="radio"/> select units <input type="radio"/> mg/L <input type="radio"/> mg/dL
Creatine kinase	_____
Select Creatine kinase units	<input type="radio"/> U/L <input type="radio"/> IU/L
Troponin I	_____
Select Troponin I units	<input type="radio"/> select units <input type="radio"/> ug/L <input type="radio"/> ng/L <input type="radio"/> ng/mL <input type="radio"/> ng/dL
Troponin	_____

Select Troponin units	<input type="radio"/> select units <input type="radio"/> ng/L <input type="radio"/> ng/mL <input type="radio"/> ug/L
Albumin	_____
Select Albumin units	<input type="radio"/> select units <input type="radio"/> g/dL <input type="radio"/> mmol/L
Eosinophils	_____
Select Eosinophils units	<input type="radio"/> 10 <sup>9</sup> /L <input type="radio"/> 10 <sup>6</sup> /L <input type="radio"/> %
Erythrocyte Sedimentation Rate (mm/h)	_____
Monocytes	_____
Select Monocytes units	<input type="radio"/> select units <input type="radio"/> 10 <sup>9</sup> /L <input type="radio"/> 10 <sup>6</sup> /L
Monocytes (%)	_____
Basophils (10 <sup>9</sup> /L)	_____
Basophils (%)	_____
CEREBRAL SPINAL FLUID	_____
Enter CSF analysis for this date?	<input type="radio"/> Yes <input type="radio"/> No
Pressure (cm of water)	_____
Appearance	<input type="radio"/> Clear and colourless <input type="radio"/> Turbid/cloudy <input type="radio"/> Xanthochromic <input type="radio"/> Blood stained <input type="radio"/> Other
White blood cell count (cells/mm <sup>3</sup> )	_____
Red blood cell count (cells/mm <sup>3</sup> )	_____
Glucose level (mg/dL)	_____
Protein level (mg/dL)	_____
Culture result	<input type="radio"/> Growth <input type="radio"/> No growth <input type="radio"/> Not tested
Please specify the CSF culture result:	_____
Other CSF findings	<input type="radio"/> Yes <input type="radio"/> No
Please specify other CSF findings	_____
Select Please specify the CSF culture result:	_____
Specify other Please specify the CSF culture result:	_____
MALARIA	_____
Malaria test performed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Malaria test date	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Malaria test type	<input type="radio"/> Rapid antigen test <input type="radio"/> Malaria film
Malaria test result	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown
<b>IMAGING</b>	
Enter Imaging data for this date?	<input type="radio"/> Yes <input type="radio"/> No
X-Ray	_____
Was a chest X-Ray performed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Chest X-Ray date	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Chest X-Ray result	<input type="checkbox"/> Normal <input type="checkbox"/> Pulmonary oedema <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pleural effusion <input type="checkbox"/> Other
Describe other chest X-Ray result	_____
CT CHEST	_____
CT Chest performed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
CT Chest date	[ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ]
Lung infiltrates present	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
CT Chest result	<input type="checkbox"/> Normal <input type="checkbox"/> Pulmonary infiltrates <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pleural effusion <input type="checkbox"/> Other
Describe other CT chest result	_____
Side(s) where pleural effusion identified	<input type="checkbox"/> Right <input type="checkbox"/> Left
CT BRAIN	_____
CT Brain performed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
CT Brain date	[ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ]
CT Brain Findings	_____
MRI BRAIN	_____
MRI performed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
MRI date	[ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ]
MRI Findings	_____
EEG	_____
EEG performed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
EEG date	[ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ]
EEG Findings	_____
Other imaging performed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Please specify other findings on imaging:	_____

### outcome\_medication

**MEDICATION: While hospitalised were any of the following administered or prescribed on discharge? For all questions of duration, please count the number of calendar days that the patient received the treatment. For treatments that were stopped and restarted, count those days on which the treatment was given but don't count any calendar days on which it was not given at all.**

Select all agents administered while hospitalised or at discharge.	_____
Select other agents administered while hospitalised or at discharge	<input type="checkbox"/> Analgesic <input type="checkbox"/> Antihistamine <input type="checkbox"/> Antiprotozoal <input type="checkbox"/> Topical antibiotic <input type="checkbox"/> Other
Specify other agents administered while hospitalised or at discharge	_____
Antiviral	_____
Select Antiviral	_____
Specify other Antiviral	_____



Antibiotic	_____
Select Antibiotic	_____
Specify other Antibiotic	_____
Topical antibiotic	<input type="radio"/> Penicillins <input type="radio"/> Cephalosporins <input type="radio"/> Tetracyclines <input type="radio"/> Aminoglycosides <input type="radio"/> Macrolides <input type="radio"/> Sulfonamides and trimethoprim <input type="radio"/> Quinolones <input type="radio"/> Other
Corticosteroid	_____
Corticosteroid route	<input type="radio"/> Oral <input type="radio"/> IV <input type="radio"/> Topical <input type="radio"/> Inhaled
Select Corticosteroid	↓ Beclomethasone (Beclometasone, Beconase) ↓ Betamethasone (Celestone, Betnelan) ↓ Budesonide (Pulmicort) ↓ Cortisone (Cortone) ↓ Fludrocortisone (Astonin, Florinef) ↓ Fluticasone (Flovent, Flonase) ↓ Mometasone (Asmanex, Elocon, Nasonex) ↓ Triamcinolone (Kenalog, Aristocort) ↓ Other
Specify other Corticosteroid	_____
Anticoagulation	_____
Anticoagulation route	<input type="radio"/> Oral <input type="radio"/> Subcutaneous <input type="radio"/> IV
Select Anticoagulation	↓ Alteplase (Activase) ↓ Argatroban (Acova) ↓ Bivalirudin (Angiomax) ↓ Dalteparin (Fragmin) ↓ Desirudin (Iprivask) ↓ Edoxaban (Savaysa, Lixiana) ↓ Fondaparinux (Arixtra) ↓ Lepirudin (Refludan) ↓ Streptokinase ↓ Ticlopidine (Ticlid) ↓ Tinzaparin (Innohep) ↓ Urokinase (Kinlytic) ↓ Other
Specify other Anticoagulation	_____
Antifungal agent	<input type="radio"/> Clotrimazole <input type="radio"/> Econazole <input type="radio"/> Miconazole <input type="radio"/> Terbinafine <input type="radio"/> Fluconazole <input type="radio"/> Ketoconazole <input type="radio"/> Nystatin <input type="radio"/> Amphotericin <input type="radio"/> Other
Specify other agent	_____
Date agent started / first dose	[ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ]
Date agent ended / last dose	[ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ]
Total number of days treatment given	_____
Frequency	_____
Dose	_____
Units	_____
Total number of doses (# of times the drug was injected/ swallowed/infused/inserted/applied, inhaled)	_____

## outcome

DIAGNOSIS	
Other pathogen(s) detected	_____
Select other pathogen(s) detected	_____
Specify other pathogen(s) detected	_____
Any additional other pathogen(s) detected ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>Select additional other pathogen(s) detected 2	_____

>Specify other pathogen(s) detected 2	_____
>Any additional other pathogen(s) detected ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
->Select additional other pathogen(s) detected 3	_____
->Specify other pathogen(s) detected 3	_____
->Any additional other pathogen(s) detected ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>->Select additional other pathogen(s) detected 4	_____
>->Specify other pathogen(s) detected 4	_____
>->Any additional other pathogen(s) detected ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
->->Select additional other pathogen(s) detected 5	_____
->->Specify other pathogen(s) detected 5	_____
<b>COMPLICATIONS: Experienced any time during hospitalisation.</b>	
Viral pneumonia / pneumonitis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Myocardial infarction	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Cardiomyopathy	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Congestive heart failure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Stroke / cerebrovascular accident	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Thromboembolism	_____
Thromboembolism	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Anaemia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Shock	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Seizure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Focal neurological signs	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Encephalitis / Meningitis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Sepsis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Coagulation disorder / DIC	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Any other organ complications	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Specify other organ complications	_____
Acute Respiratory Distress Syndrome (ARDS)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Myocarditis / pericarditis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Acute renal injury / acute renal failure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Severe liver disease (new onset)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Jaundice	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Hepatic encephalopathy (any grade)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Liver dysfunction	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown

Other complication(s)	_____
Select other complication(s)	_____
Specify other complication(s)	_____
Any additional other complication(s) ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>Select additional other complication(s) 2	_____
>Specify other complication(s) 2	_____
>Any additional other complication(s) ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
->Select additional other complication(s) 3	_____
->Specify other complication(s) 3	_____
->Any additional other complication(s) ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
>->Select additional other complication(s) 4	_____
>->Specify other complication(s) 4	_____
>->Any additional other complication(s) ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
->->Select additional other complication(s) 5	_____
->->Specify other complication(s) 5	_____
<b>INTERVENTIONS: While hospitalised, were any of the following administered/undertaken? For all questions of duration, please count the number of calendar days that the patient received the treatment. For treatments that were stopped and restarted, count those days on which the treatment was given but don't count any calendar days on which it was not given at all.</b>	
PARENTERAL / IV FLUID	_____
Parenteral / IV fluid?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Select all Parenteral / IV fluid that were administered	<input type="checkbox"/> Crystalloid <input type="checkbox"/> Albumin <input type="checkbox"/> Gelatin <input type="checkbox"/> Starches <input type="checkbox"/> Other
Total Crystalloid volume given during admission (mL)	_____
Total Albumin volume given during admission (mL)	_____
Total Gelatin volume given during admission (mL)	_____
Total Starches volume given during admission (mL)	_____
Specify other fluid	_____
Total volume given during admission (mL)	_____
Reason(s) for IV fluid (check all that apply)	<input type="checkbox"/> Shock <input type="checkbox"/> High/rising haematocrit <input type="checkbox"/> Anorexia <input type="checkbox"/> Persistent vomiting <input type="checkbox"/> Other
Specify other reason for IV fluid	_____

Date first IV fluid started	_____
Date last IV fluid ended	_____
BLOOD PRODUCT TRANSFUSION	_____
Blood product tranfusion?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Select all blood product transfusion that were administered	<input type="checkbox"/> Platelets <input type="checkbox"/> Cryoprecipitate <input type="checkbox"/> Whole blood/packed RBC <input type="checkbox"/> Frozen fresh plasma <input type="checkbox"/> Fibrinogen concentrate
Total number of Platelets (mL/24 hours)	_____
Total number of Cryoprecipitate (mL/24 hours)	_____
Total number of Whole blood/packed RBC (mL/24 hours)	_____
Total number of Fresh Frozen Plasma (FFP) (mL/24 hours)	_____
Total number of Fibrinogen concentrate (mL/24 hours)	_____
Intravenous Immunoglobulin?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Plasmapheresis/Plasma Exchange?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Days on plasma exchange support	_____
Any supplemental oxygen during the observation	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Select ALL types of respiratory support the patient received	<input type="checkbox"/> Nasal prong <input type="checkbox"/> Face mask <input type="checkbox"/> High-flow nasal oxygen <input type="checkbox"/> Non-invasive ventilation <input type="checkbox"/> Invasive ventilation <input type="checkbox"/> ECLS/ ECMO
Highest FiO2	_____
Select Highest FiO2 units	<input type="radio"/> select units <input type="radio"/> Fraction, 0.21-1.0 <input type="radio"/> %, 21-100
Number of calendar days the patient received any respiratory support	_____
What type of Non-invasive ventilation?	<input type="radio"/> CPAP <input type="radio"/> BIPAP <input type="radio"/> Other <input type="radio"/> Unknown
Neuromuscular blocking agents?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Tracheostomy inserted?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Renal replacement therapy (RRT) or dialysis?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Total RRT or dialysis duration during observation (days)	_____
Inotropes/vasopressors?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Total Inotropes/vasopressor duration during observation (days)	_____
ICU/ITU/High Dependency Unit/Intermediate Care Unit admission ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Date of first ICU admission	[ _D ][ _D ]/[ _M ][ _M ]/[ _2 ][ _0 ][ _Y ][ _Y ]
Duration of first ICU admission (days)	_____
Was the patient admitted to ICU more than once?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Date of final ICU admission	[ _D ][ _D ]/[ _M ][ _M ]/[ _2 ][ _0 ][ _Y ][ _Y ]

Duration of final ICU admission (days)	_____
<b>OUTCOME</b>	
What was the Primary/Main Clinical Diagnosis?	_____
Was the Primary/Main Diagnosis Non-infectious?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Was there any secondary diagnosis?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Specify secondary diagnosis	_____
Outcome date	[ _D ][ _D ]/[ _M ][ _M ]/[ _2 ][ _0 ][ _Y ][ _Y ]
Outcome	<input type="radio"/> Discharged alive <input type="radio"/> Still hospitalised <input type="radio"/> Transfer to other facility <input type="radio"/> Death <input type="radio"/> Palliative discharge <input type="radio"/> Discharged against medical advice <input type="radio"/> Unknown

### outcome\_pathogen\_testing

<b>TEST</b>	
Collection Date	[ _D ][ _D ]/[ _M ][ _M ]/[ _2 ][ _0 ][ _Y ][ _Y ]
Biospecimen Type	<input type="radio"/> Nasal/NP swab <input type="radio"/> Throat swab <input type="radio"/> Combined nasal/NP + throat swab <input type="radio"/> Sputum <input type="radio"/> BAL <input type="radio"/> ETA <input type="radio"/> Lesion swab <input type="radio"/> Urine <input type="radio"/> Faeces/rectal swab <input type="radio"/> Blood <input type="radio"/> Other
Please specify biospecimen type	_____
Lab test method	<input type="radio"/> PCR <input type="radio"/> IgG <input type="radio"/> Culture <input type="radio"/> IgM <input type="radio"/> Antigen detection <input type="radio"/> Other
Please specify other lab test method	_____
Pathogen Tested/Detected	_____
Select Pathogen Tested/Detected	_____
Specify other Pathogen Tested/Detected	_____
CT Value	_____
Was a HIV test performed during admission?	<input type="checkbox"/> Yes - Positive (serologically confirmed) <input type="checkbox"/> Yes - Positive (rapid diagnostic test) <input type="checkbox"/> Yes - Negative (not-infected) <input type="checkbox"/> Not tested

### outcome\_assessment

<b>ASSESSMENT (Complete this section in full for each outcome assessment performed)</b>	
Assessment Date	[ _D ][ _D ]/[ _M ][ _M ]/[ _2 ][ _0 ][ _Y ][ _Y ]
Evaluation method	<input type="radio"/> In person <input type="radio"/> Telephone
Assessment patient outcome	<input type="radio"/> Discharged alive <input type="radio"/> Still hospitalised <input type="radio"/> Discharged against medical advice <input type="radio"/> Transfer to other facility <input type="radio"/> Death <input type="radio"/> Palliative discharge <input type="radio"/> Loss to follow-up
First / earliest date on which the selected outcome was true	[ _D ][ _D ]/[ _M ][ _M ]/[ _2 ][ _0 ][ _Y ][ _Y ]
Does the patient re-admit to hospital after discharge from acute illness	<input type="radio"/> Yes <input type="radio"/> No
Date of hospitalisation	[ _D ][ _D ]/[ _M ][ _M ]/[ _2 ][ _0 ][ _Y ][ _Y ]
Reason for hospitalisation	_____
Date of death	[ _D ][ _D ]/[ _M ][ _M ]/[ _2 ][ _0 ][ _Y ][ _Y ]

Cause of death	_____
Reason for loss to follow-up	_____
Final Liverpool Outcome score (LOS)	_____
Total Liverpool Outcome score (LOS)	_____
Glasgow Outcome Scale Extended (GOS-E)	_____
Glasgow Outcome Scale Extended Pediatric Revision (GOS-E Peds) if patient is ≤ 16 years of age.	_____
Modified Rankin Scale (mRS) score	_____
MMSE score	_____
Neurological complications	<input type="checkbox"/> None <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Motor impairment <input type="checkbox"/> Psychological disturbance <input type="checkbox"/> Cognitive impairment <input type="checkbox"/> Visual impairment <input type="checkbox"/> Other
Specify Seizure disorder	_____
Date of Seizure disorder	[ _D ][ _D ]/[ _M ][ _M ]/[ _2 ][ _0 ][ _Y ][ _Y ]
Specify Motor impairment	_____
Date of Motor impairment	[ _D ][ _D ]/[ _M ][ _M ]/[ _2 ][ _0 ][ _Y ][ _Y ]
Specify Psychological disturbance	_____
Date of Psychological disturbance	[ _D ][ _D ]/[ _M ][ _M ]/[ _2 ][ _0 ][ _Y ][ _Y ]
Specify Cognitive impairment	_____
Date of Cognitive impairment	[ _D ][ _D ]/[ _M ][ _M ]/[ _2 ][ _0 ][ _Y ][ _Y ]
Specify Visual impairment	_____
Date of Visual impairment	[ _D ][ _D ]/[ _M ][ _M ]/[ _2 ][ _0 ][ _Y ][ _Y ]
Specify other neurological abnormality	_____
Date of Other neurological abnormality	[ _D ][ _D ]/[ _M ][ _M ]/[ _2 ][ _0 ][ _Y ][ _Y ]