ISARIC CORE CRF

DESIGN OF THIS CASE REPORT FORM (CRF)

This CRF is set up in modules to be used for recording data on test. A template for completion instructions is below. This should be tailored to the objectives of your data collection.

PRESENTATION FORM: ALWAYS complete on the first day of presentation/admission/assessment.
DAILY FORM: ALWAYS complete on the first day of presentation/admission/assessment
DAILY FORM: IF APPLICABLE, complete on the day of admission to ICU/high dependency unit/critical care (if different date to the date of first presentation/admission)
DAILY FORM: OPTION to complete on days that research specific samples are taken
DAILY FORM: OPTION to complete daily if of interest for specific analysis.
OUTCOME FORM: ALWAYS complete at discharge or death or at the end of the study period
Continue to follow-up patients who transfer between wards.

Forms	Hospital admission / initial assessment	Admission to ICU (if applicable)	Research sample taken (optional)	As per site protocol (optional)	Discharge / death / end of study
PRESENTATION FORM	COMPLETE				
DAILY FORM	COMPLETE	(COMPLETE)	(COMPLETE)	(COMPLETE)	
OUTCOME FORM					COMPLETE

GENERAL GUIDANCE

• Contact ISARIC Global Support Centre at data@isaric.org
• The CRF is designed to collect data obtained through examination, interview, review of hospital notes, or extraction from electronic health records. Data may be collected prospectively or retrospectively if the patient is enrolled after the date of presentation to a health facility.
• Please refer to the CRF Completion Guideline for detailed guidance on how to complete these forms.
• Your institution may capture data:
(a) on the ISARIC hosted REDCap database - contact ISARIC for access,
(b) to a REDCap database hosted at your institution - contact ISARIC if you would like support to set this up, or
(c) on a database or electronic health record system at your institution - contact ISARIC to support data mapping.
• Participant Identification Numbers consist of a 5-digit site code and a 4-digit participant number.
Please obtain a site code and register on the data management system by contacting ISARIC. Participant numbers should be assigned sequentially for each site beginning with 0001 or in blocks, possibly including alpha characters, where useful. E.g., Ward X will assign numbers from 0001 or A001 onwards and Ward Y will assign numbers from 5001 or B001 onwards.
• For participants who return for re-admission to the same site, start a new form with a different Participant Identification Number. Please check "YES-admitted previously to this facility" in the RE-ADMISSION section. Enter as 2 separate records if you are using a REDCap (or similar) database.
• For participants who transfer between two sites that are both collecting data on this form, it is preferred to have the data entered by a single site as a single admission, under the same Participant Identification Number. When this is not possible, the first site should record "Transfer to other facility" as an OUTCOME, and the second site should start a new form with a new patient number and indicate "YES- then transferred to this facility" in the RE-ADMISSION AND PREVIOUS PIN section.
• Selections with circles (○) are single selection (choose one answer only). Selections with square boxes (□) are multiple selection (choose as many answers as are applicable). Unk = Unknown

presentation

Participant Identification Number (PIN):	
INCLUSION CRITERIA	
Does the patient have reported/ measured fever (axillary temperature >38.5°C [101.3 °F])?	○ Yes ○ 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).	○ Yes ○ No
Participant is enrolled in the icddr,b-IEDCR NiV surveillance programme.	○ Yes ○ No
Participant (or their legal representative) has provided consent to participate in this study.	○ Yes ○ No
EXCLUSION CRITERIA	
Does the patient have a clear alternative non-infectious diagnosis (either clinical or laboratory/imaging confirmed diagnosis) that explains the acute presentation	○ Yes ○ No
ONSET & ADMISSION	
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)	○ Abdominal pain ○ Anorexia ○ Bleeding (Haemorrhage) ○
Select First symptom (select multiple if occurred at same time)	_____
Specify other First symptom (select multiple if occurred at same time)	_____
RE-ADMISSION AND PREVIOUS PIN	
Was the patient admitted previously or transferred from any other facility during this illness episode?	○ YES-admitted previously to this facility and discharged ○ YES-admitted to other facility and discharged ○ YES-admitted to another facility, then transferred to this facility ○ No ○ Unknown
Date of earliest admission for this infection	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
DEMOGRAPHICS	
Sex at Birth	○ Male ○ Female ○ Not specified/Unknown
Age	_____
Age units	○ Years ○ Months ○ Days
Height (cm)	_____
Weight (kg)	_____
Employed as a healthcare worker	○ Yes, patient facing ○ Yes, laboratory ○ Yes, no patients/laboratory ○ No ○ Unknown

Primary location of occupation	○ Home-working or unemployed ○ Indoors-office/health/education/hospitality/business/homes ○ Indoors-factory ○ Outdoors-animal contact (vet, animal farmer, abattoir worker) ○ Outdoors-agriculture/forestry/fisheries ○ Outdoors-DPS collector ○ Outdoors-construction/industrial/mining ○ Armed Forces ○ Student ○ Other ○ Unknown
Specify other primary location of occupation	_____
Patient's city of residence	○ Same as health care facility ○ Different from health care facility ○ Unknown
Specify region (sub-district) of residence	_____
EXPOSURE HISTORY IN PREVIOUS 14 DAYS	
Drinking raw date palm sap (DPS)	○ Yes ○ No ○ Unknown
EXPOSURE HISTORY	
Drinking fermented DPS	○ Yes ○ No ○ Unknown
Eating bat/bird eaten fruits	○ Yes ○ No ○ Unknown
Close contact with patient with similar illness	○ Yes ○ No ○ Unknown
Contact with bat/s	○ Yes ○ No ○ Unknown
Contact with pig/s	○ Yes ○ No ○ Unknown
Contact with domestic animal/s	○ Yes ○ No ○ Unknown
Other type of exposure history	○ Yes ○ No ○ Unknown
Specify other type of exposure.	_____
PREGNANCY	
Pregnant	○ Yes ○ No ○ Unknown
Gestational weeks assessment (weeks)	_____
Post-partum (within 6 weeks of delivery)	○ Yes ○ No ○ Unknown
Delivery date	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Pregnancy outcome	○ Live birth ○ Still birth ○ Termination
Gestational weeks at pregnancy outcome	_____
INFANT: less than 12 months old	
Gestational outcome	○ Term birth (>=37wk GA) ○ Preterm birth (< 37wk GA) ○ Unknown
Vaccinations appropriate for age/country	○ Yes ○ No ○ Unknown
CO-MORBIDITIES AND RISK FACTORS: Existing prior to presentation or admission with this current illness and is ongoing (remains an active medical condition)	
Chronic cardiac disease (not hypertension)	○ Yes ○ No ○ Unknown
Hypertension (physician diagnosed)	○ Yes ○ No ○ Unknown
Chronic pulmonary disease (not asthma)	○ Yes ○ No ○ Unknown
Asthma (physician diagnosed)	○ Yes ○ No ○ Unknown

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

MEDICATION PREVIOUS 14-DAYS: include all taken within 14 days prior to this most recent admission / presentation	
Steroid	○ Yes ○ No ○ Unknown
Steroid administration route	○ Oral ○ Inhaled ○ IV ○ 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	○ Oral ○ Inhaled ○ IV ○ Unknown
Any additional steroid ?	○ Yes ○ No ○ 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	○ Oral ○ Inhaled ○ IV ○ Unknown
>Any additional steroid ?	○ Yes ○ No ○ 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	○ Oral ○ Inhaled ○ IV ○ Unknown
->Any additional steroid ?	○ Yes ○ No ○ 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	○ Oral ○ Inhaled ○ IV ○ Unknown
>->Any additional steroid ?	○ Yes ○ No ○ Unknown

->->Select additional steroid 5	↧ 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 5	_____
->->Steroid administration route 5	○ Oral ○ Inhaled ○ IV ○ Unknown
Immunosuppressant agents (not steroids)	○ Yes ○ No ○ Unknown
Select immunosuppressant agents (not steroids)	_____
Specify other immunosuppressant agents (not steroids)	_____
Any additional immunosuppressant agents (not steroids) ?	○ Yes ○ No ○ Unknown
>Select additional immunosuppressant agents (not steroids) 2	_____
>Specify other immunosuppressant agents (not steroids) 2	_____
>Any additional immunosuppressant agents (not steroids) ?	○ Yes ○ No ○ Unknown
->Select additional immunosuppressant agents (not steroids) 3	_____
->Specify other immunosuppressant agents (not steroids) 3	_____
->Any additional immunosuppressant agents (not steroids) ?	○ Yes ○ No ○ Unknown
>->Select additional immunosuppressant agents (not steroids) 4	_____
>->Specify other immunosuppressant agents (not steroids) 4	_____
>->Any additional immunosuppressant agents (not steroids) ?	○ Yes ○ No ○ Unknown
->->Select additional immunosuppressant agents (not steroids) 5	_____
->->Specify other immunosuppressant agents (not steroids) 5	_____
Antibiotics	○ Yes ○ No ○ Unknown
Select antibiotics	_____
Specify other antibiotics	_____
Any additional antibiotics ?	○ Yes ○ No ○ Unknown
>Select additional antibiotics 2	_____
>Specify other antibiotics 2	_____
>Any additional antibiotics ?	○ Yes ○ No ○ Unknown

->Select additional antibiotics 3	_____
->Specify other antibiotics 3	_____
->Any additional antibiotics ?	○ Yes ○ No ○ Unknown
>->Select additional antibiotics 4	_____
>->Specify other antibiotics 4	_____
>->Any additional antibiotics ?	○ Yes ○ No ○ Unknown
->->Select additional antibiotics 5	_____
->->Specify other antibiotics 5	_____
Antiviral	○ Yes ○ No ○ Unknown
Select antiviral	_____
Specify other antiviral	_____
Any additional antiviral ?	○ Yes ○ No ○ Unknown
>Select additional antiviral 2	_____
>Specify other antiviral 2	_____
>Any additional antiviral ?	○ Yes ○ No ○ Unknown
->Select additional antiviral 3	_____
->Specify other antiviral 3	_____
->Any additional antiviral ?	○ Yes ○ No ○ Unknown
>->Select additional antiviral 4	_____
>->Specify other antiviral 4	_____
>->Any additional antiviral ?	○ Yes ○ No ○ Unknown
->->Select additional antiviral 5	_____
->->Specify other antiviral 5	_____
Anticoagulant	○ Yes ○ No ○ Unknown
Select anticoagulant	_____
Specify other anticoagulant	_____
Any additional anticoagulant ?	○ Yes ○ No ○ Unknown
>Select additional anticoagulant 2	_____
>Specify other anticoagulant 2	_____
>Any additional anticoagulant ?	○ Yes ○ No ○ Unknown
->Select additional anticoagulant 3	_____
->Specify other anticoagulant 3	_____
->Any additional anticoagulant ?	○ Yes ○ No ○ Unknown
>->Select additional anticoagulant 4	_____
>->Specify other anticoagulant 4	_____
>->Any additional anticoagulant ?	○ Yes ○ No ○ Unknown
->->Select additional anticoagulant 5	_____
->->Specify other anticoagulant 5	_____

Intravenous fluid	○ Yes ○ No ○ 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	○ Yes ○ No
Intravenous fluid type	↧ Crystalloid ↧ Albumin ↧ Gelatin ↧ Starches, ↧ Fibrinogen concentrate ↧ Other fluid
Other pathogen-targeted medications	○ Yes ○ No ○ Unknown
Select other pathogen-targeted medications	_____
Specify other pathogen-targeted medications	_____
Any additional other pathogen-targeted medications ?	○ Yes ○ No ○ Unknown
>Select additional other pathogen-targeted medications 2	_____
>Specify other pathogen-targeted medications 2	_____
>Any additional other pathogen-targeted medications ?	○ Yes ○ No ○ Unknown
->Select additional other pathogen-targeted medications 3	_____
->Specify other pathogen-targeted medications 3	_____
->Any additional other pathogen-targeted medications ?	○ Yes ○ No ○ Unknown
>->Select additional other pathogen-targeted medications 4	_____
>->Specify other pathogen-targeted medications 4	_____
>->Any additional other pathogen-targeted medications ?	○ Yes ○ No ○ Unknown
->->Select additional other pathogen-targeted medications 5	_____
->->Specify other pathogen-targeted medications 5	_____
VACCINATION	
Vaccinated for COVID-19 (ever)	○ Yes ○ No ○ Unknown
Date of most recent COVID-19 vaccine	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Vaccinated for influenza (ever)	○ Yes ○ No ○ 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)	○ Yes-reported ○ Yes - confirmed with vaccination card ○ No ○ Unknown

Varicella vaccination	○ Yes-reported ○ Yes - confirmed with vaccination card ○ No ○ Unknown
JE vaccination	○ Yes-reported ○ Yes - confirmed with vaccination card ○ No ○ Unknown
SIGNS AND SYMPTOMS ON ADMISSION: first data, from onset of this acute illness to day of presentation or admission	
Fever / chills / rigors	○ Yes ○ No ○ Unknown
Restlessness	○ Yes ○ No ○ Unknown
Fatigue / Malaise / Lethargy	○ Yes ○ No ○ Unknown
Weight loss	○ Yes ○ No ○ Unknown
Cough	○ Yes, non-productive ○ Yes, productive ○ Yes, with haemoptysis ○ No ○ Unknown
Sore throat	○ Yes ○ No ○ Unknown
Runny nose (rhinorrhoea)	○ Yes ○ No ○ Unknown
Wheezing	○ Yes ○ No ○ Unknown
Shortness of breath	○ Yes ○ No ○ Unknown
Lower chest wall indrawing	○ Yes ○ No ○ Unknown
Abdominal pain	○ Yes ○ No ○ Unknown
Diarrhoea	○ Yes ○ No ○ Unknown
Vomiting / Nausea	○ Yes ○ No ○ Unknown
Anorexia	○ Yes ○ No ○ Unknown
Parotitis	○ Yes ○ No ○ Unknown
Exessive salivation	○ Yes ○ No ○ Unknown
Orchitis	○ Yes ○ No ○ Unknown
Bleeding / Haemorrhage	○ Yes ○ No ○ Unknown
Specify bleeding / haemorrhage site(s)	☐ Skin ☐ Nose ☐ Gums ☐ GI tract ☐ Urinary tract ☐ Vagina ☐ Other
Jaundice	○ Yes ○ No ○ Unknown
Muscle aches / Myalgia	○ Yes ○ No ○ Unknown
Joint pain / Arthralgia	○ Yes ○ No ○ Unknown
Headache	○ Yes ○ No ○ Unknown
Neck stiffness	○ Yes ○ No ○ Unknown
Photophobia	○ Yes ○ No ○ Unknown
Retro-orbital pain	○ Yes ○ No ○ Unknown
Seizures / Convulsions	○ Yes ○ No ○ Unknown
Type of seizure	○ Focal ○ Generalised tonic clonic ○ Unknown
Altered consciousness / confusion	○ Yes ○ No ○ Unknown
Psychological disturbance	○ Yes ○ No ○ Unknown
Myoclonus	○ Yes ○ No
Cerebellar signs	○ Yes ○ No
Tremor	○ Yes ○ No
Dystonia	○ Yes ○ No

Specify dystonia site	☐ Right Upper Extremity ☐ Right Lower Extremity ☐ Left Upper Extremity ☐ Left Lower Extremity ☐ Face ☐ Other
Specify other dystonia site	_____
Facial palsy	○ Yes ○ No
Dysarthria	○ Yes ○ No
Dysphasia	○ Yes ○ No
Plantar reflex	○ Equivocal ○ Extensor ○ Flexor ○ Absent
Deep tendon reflex	○ Diminished ○ Exaggerated ○ Normal ○ Absent
Other neurological abnormality	○ Yes ○ No ○ Unknown
Specify other neurological abnormality	_____
Conjunctivitis	○ Yes ○ No ○ Unknown
Nystagmus	○ Yes ○ No
Ptosis	○ Yes, unilateral ○ Yes, bilateral ○ No
Skin rash	○ Yes ○ No ○ Unknown
Inability to walk	○ Yes ○ No ○ Unknown
Mobility status	○ Fully ambulant ○ Ambulant, but with some assistance ○ Bedridden
Other sign(s) or abnormality	○ Yes ○ No ○ Unknown
Select other sign(s) or abnormality	_____
Specify other sign(s) or abnormality	_____
Any additional other sign(s) or abnormality ?	○ Yes ○ No ○ Unknown
>Select additional other sign(s) or abnormality 2	_____
>Specify other sign(s) or abnormality 2	_____
>Any additional other sign(s) or abnormality ?	○ Yes ○ No ○ Unknown
->Select additional other sign(s) or abnormality 3	_____
->Specify other sign(s) or abnormality 3	_____
->Any additional other sign(s) or abnormality ?	○ Yes ○ No ○ Unknown
>->Select additional other sign(s) or abnormality 4	_____
>->Specify other sign(s) or abnormality 4	_____
>->Any additional other sign(s) or abnormality ?	○ Yes ○ No ○ Unknown
->->Select additional other sign(s) or abnormality 5	_____
->->Specify other sign(s) or abnormality 5	_____

daily

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

Specify dystonia site	☐ Right Upper Extremity ☐ Right Lower Extremity ☐ Left Upper Extremity ☐ Left Lower Extremity ☐ Face ☐ Other
Specify other dystonia site	_____
Facial palsy	○ Yes ○ No ○ Unknown
Dysarthria	○ Yes ○ No ○ Unknown
Dysphasia	○ Yes ○ No ○ Unknown
Plantar reflex	○ Equivocal ○ Extensor ○ Flexor ○ Absent ○ Unknown
Deep tendon reflex	○ Diminished ○ Exaggerated ○ Normal ○ Absent ○ Unknown
Other neurological abnormality	○ Yes ○ No ○ Unknown
Specify other neurological abnormality	_____
Conjunctivitis	○ Yes ○ No ○ Unknown
Nystagmus	○ Yes ○ No ○ Unknown
Ptosis	○ Yes, unilateral ○ Yes, bilateral ○ No
Skin rash	○ Yes ○ No ○ Unknown
Inability to walk	○ Yes ○ No ○ Unknown
Mobility status	○ Fully ambulant ○ Ambulant, but with some assistance ○ Bedridden
Other sign(s) or symptom(s)	○ Yes ○ No ○ Unknown
Select other sign(s) or symptom(s)	_____
Specify other sign(s) or symptom(s)	_____
Any additional other sign(s) or symptom(s) ?	○ Yes ○ No ○ 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) ?	○ Yes ○ No ○ 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) ?	○ Yes ○ No ○ 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) ?	○ Yes ○ No ○ Unknown
->->Select additional other sign(s) or symptom(s) 5	_____
->->Specify other sign(s) or symptom(s) 5	_____
VITAL SIGNS & ASSESSMENTS: Record the value furthest from normal range between 00:00 to 24:00 on day of assessment.	

Enter Vital Signs data for this date?	○ Yes ○ 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	○ Yes ○ No ○ Unknown
FiO2 at time of lowest SpO2	_____
Select FiO2 at time of lowest SpO2 units	○ select units ○ %, 21-100
Capillary refill time >2seconds	○ Yes ○ No ○ Unknown
AVPU	○ Alert ○ Verbal ○ Pain ○ Unresponsive
Glasgow Coma Score (GCS / 15)	_____
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 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.	
Enter Laboratory Results data for this date?	○ Yes ○ 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	○ Yes ○ No
FBC (Full Blood Count)	○ Yes ○ No
U&E; (Renal profile)	○ Yes ○ No
(LFT) Liver profile	○ Yes ○ No
Bone profile	○ Yes ○ No
Blood glucose	○ Yes ○ No
HIV serology (only at admission)	○ Yes ○ No
Haemoglobin	_____
Select Haemoglobin units	○ select units ○ g/dL ○ g/L ○ mmol/L
WBC count (10^9/L)	_____
Lymphocytes	_____
Select Lymphocytes units	○ select units ○ 10^9/L ○ 10^6/L ○ cells/uL ○ 10^3/uL ○ %
Neutrophils	_____
Select Neutrophils units	○ select units ○ 10^9/L ○ 10^6/L ○ cells/uL ○ 10^3/uL ○ %
Hematocrit	_____
Select Hematocrit units	○ select units ○ % ○ fraction of 1 ○ L/L

Platelets	_____
Select Platelets units	○ select units ○ 10^9/L ○ 10^6/L ○ 10^3/uL
Activated Partial Thromboplastin Time/APTT (sec)	_____
Prothrombin Time/PT	_____
Select Prothrombin Time/PT units	○ select units ○ sec ○ Prothrombin Intl. Normalized Ratio
TQ/INR	_____
ALT/SGPT (U/L)	_____
Total Bilirubin	_____
Select Total Bilirubin units	○ select units ○ umol/L ○ mg/dL
ALP (IU/L)	_____
AST/SGOT (U/L)	_____
Random glucose	_____
Select Random glucose units	○ select units ○ mmol/L ○ mg/dL ○ g/L
Gamma Glutamyl Transferase/GGT (U/L)	_____
Urea/BUN	_____
Select Urea/BUN units	○ select units ○ mmol/L ○ mg/dL
Creatinine	_____
Select Creatinine units	○ select units ○ umol/L ○ mg/dL
Sodium	_____
Select Sodium units	○ select units ○ mmol/L ○ mEq/L
Potassium	_____
Select Potassium units	○ select units ○ mmol/L ○ mEq/L
Procalcitonin	_____
Select Procalcitonin units	○ select units ○ ug/L ○ ng/mL
CRP	_____
Select CRP units	○ select units ○ mg/L ○ mg/dL
Creatine kinase	_____
Select Creatine kinase units	○ U/L ○ IU/L
Troponin I	_____
Select Troponin I units	○ select units ○ ug/L ○ ng/L ○ ng/mL ○ ng/dL
Troponin	_____
Select Troponin units	○ select units ○ ng/L ○ ng/mL ○ ug/L
Albumin	_____
Select Albumin units	○ select units ○ g/dL ○ mmol/L
Eosinophils	_____
Select Eosinophils units	○ 10^9/L ○ 10^6/L ○ %

Erythrocyte Sedimentation Rate (mm/h)	_____
Monocytes	_____
Select Monocytes units	○ select units ○ 10^9/L ○ 10^6/L
Monocytes (%)	_____
Basophils (10^9/L)	_____
Basophils (%)	_____
Enter CSF analysis for this date?	○ Yes ○ No
Pressure (cm of water)	_____
Appearance	○ Clear and colourless ○ Turbid/cloudy ○ Xanthochromic ○ Blood stained ○ Other
White blood cell count (cells/mm^3)	_____
Red blood cell count (cells/mm^3)	_____
Glucose level (mg/dL)	_____
Protein level (mg/dL)	_____
Culture result	○ Growth ○ No growth ○ Not tested
Please specify the CSF culture result:	_____
Other CSF findings	○ Yes ○ No
Please specify other CSF findings	_____
Select Please specify the CSF culture result:	_____
Specify other Please specify the CSF culture result:	_____
Malaria test performed	○ Yes ○ No ○ Unknown
Malaria test date	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Malaria test type	○ Rapid antigen test ○ Malaria film
Malaria test result	○ Positive ○ Negative ○ Unknown
IMAGING	
Enter Imaging data for this date?	○ Yes ○ No
Was a chest X-Ray performed?	○ Yes ○ No ○ Unknown
Chest X-Ray date	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Chest X-Ray result	☐ Normal ☐ Pulmonary oedema ☐ Pneumonia ☐ Pleural effusion ☐ Other
Describe other chest X-Ray result	_____
CT Chest performed	○ Yes ○ No ○ Unknown
CT Chest date	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Lung infiltrates present	○ Yes ○ No ○ Unknown
CT Chest result	☐ Normal ☐ Pulmonary infiltrates ☐ Pneumonia ☐ Pleural effusion ☐ Other
Describe other CT chest result	_____

Side(s) where pleural effusion identified	☐ Right ☐ Left
CT Brain performed	○ Yes ○ No ○ Unknown
CT Brain date	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
CT Brain Findings	_____
MRI performed	○ Yes ○ No ○ Unknown
MRI date	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
MRI Findings	_____
EEG performed	○ Yes ○ No ○ Unknown
EEG date	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
EEG Findings	_____
Other imaging performed	○ Yes ○ No ○ 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 retsarted, count those daus 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.	○ Antibiotic ○ Anticoagulation ○ Antifungal ○ Antipruritic ○ Antiviral ○ Convalescent plasma ○ Corticosteroid ○ Inotropes / vasopressor ○
Select other agents administered while hospitalised or at discharge	↧ Analgesic ↧ Antihistamine ↧ Antiprotozoal ↧ Topical antibiotic ↧ Other
Specify other agents administered while hospitalised or at discharge	_____
Antiviral	○ Aciclovir (Acyclovir, Zovirax) ○ Ganciclovir (Cytovene) ○ Molnupiravir (Lagevrio) ○ Nirmatrelvir/Retonavir (Paxlovid) ○ Remdesivir (Veklury) ○ Umifenovir (Arbidol) ○ Valaciclovir (Valtrex) ○
Select Antiviral	_____
Specify other Antiviral	_____
Antibiotic	_____
Select Antibiotic	_____
Specify other Antibiotic	_____
Topical antibiotic	○ Penicillins ○ Cephalosporins ○ Tetracyclines ○ Aminoglycosides ○ Macrolides ○ Sulfonamides and trimethoprim ○ Quinolones ○ Other
Corticosteroid	○ Dexamethasone (Decadron, Dexasone, Diodex) ○ Hydrocortisone (Cortef, Solu-Cortef) ○ Methylprednisolone (Medrol, Solu-Medrol) ○ Prednisolone (Prelone, Orapred) ○ Prednisone (Deltasone) ○
Corticosteroid route	○ Oral ○ IV ○ Topical ○ 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	○ Acetylsalicylic Acid (Aspirin) ○ Apixaban (Eliquis) ○ Clopidogrel (Plavix) ○ Dabigatran Etexilate (Pradaxa) ○ Enoxaparin (Lovenox) ○ Heparin (Unfractionated Heparin) ○ Rivaroxaban (Xarelto) ○ Ticagrelor (Brilinta) ○ Warfarin (Coumadin, Jantoven) ○
Anticoagulation route	○ Oral ○ Subcutaneous ○ 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	○ Clotrimazole ○ Econazole ○ Miconazole ○ Terbinafine ○ Fluconazole ○ Ketoconazole ○ Nystatin ○ Amphotericin ○ Other
Specify other agent	_____
Date agent started / first dose	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Date agent ended / last dose	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
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	○ Yes ○ No ○ Unknown
Select other pathogen(s) detected	_____
Specify other pathogen(s) detected	_____
Any additional other pathogen(s) detected ?	○ Yes ○ No ○ Unknown
>Select additional other pathogen(s) detected 2	_____
>Specify other pathogen(s) detected 2	_____
>Any additional other pathogen(s) detected ?	○ Yes ○ No ○ Unknown
->Select additional other pathogen(s) detected 3	_____
->Specify other pathogen(s) detected 3	_____
->Any additional other pathogen(s) detected ?	○ Yes ○ No ○ Unknown
>->Select additional other pathogen(s) detected 4	_____

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

->Specify other complication(s) 3	_____
->Any additional other complication(s) ?	○ Yes ○ No ○ Unknown
>->Select additional other complication(s) 4	_____
>->Specify other complication(s) 4	_____
>->Any additional other complication(s) ?	○ Yes ○ No ○ Unknown
->->Select additional other complication(s) 5	_____
->->Specify other complication(s) 5	_____
Parenteral / IV fluid?	○ Yes ○ No ○ Unknown
Select all Parenteral / IV fluid that were administered	☐ Crystalloid ☐ Albumin ☐ Gelatin ☐ Starches ☐ 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)	☐ Shock ☐ High/rising haematocrit ☐ Anorexia ☐ Persistent vomiting ☐ Other
Specify other reason for IV fluid	_____
Date first IV fluid started	_____
Date last IV fluid ended	_____
Blood product tranfusion?	○ Yes ○ No ○ Unknown
Select all blood product transfusion that were administered	☐ Platelets ☐ Cryoprecipitate ☐ Whole blood/packed RBC ☐ Frozen fresh plasma ☐ 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?	○ Yes ○ No ○ Unknown
Plasmapheresis/Plasma Exchange?	○ Yes ○ No ○ Unknown
Days on plasma exchange support	_____

Any supplemental oxygen during the observation	○ Yes ○ No ○ Unknown
Select ALL types of respiratory support the patient received	☐ Nasal prong ☐ Face mask ☐ High-flow nasal oxygen ☐ Non-invasive ventilation ☐ Invasive ventilation ☐ ECLS/ ECMO
Highest FiO2	_____
Select Highest FiO2 units	○ select units ○ Fraction, 0.21-1.0 ○ %, 21-100
Number of calendar days the patient received any respiratory support	_____
What type of Non-invasive ventilation?	○ CPAP ○ BIPAP ○ Other ○ Unknown
Neuromuscular blocking agents?	○ Yes ○ No ○ Unknown
Tracheostomy inserted?	○ Yes ○ No ○ Unknown
Renal replacement therapy (RRT) or dialysis?	○ Yes ○ No ○ Unknown
Total RRT or dialysis duration during observation (days)	_____
Inotropes/vasopressors?	○ Yes ○ No ○ Unknown
Total Inotropes/vasopressor duration during observation (days)	_____
ICU/ITU/High Dependency Unit/Intermediate Care Unit admission ?	○ Yes ○ No ○ 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?	○ Yes ○ No ○ Unknown
Date of final ICU admission	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Duration of final ICU admission (days)	_____
OUTCOME	
What was the Primary/Main Clinical Diagnosis?	_____
Was the Primary/Main Diagnosis Non-infectious?	○ Yes ○ No ○ Unknown
Was there any secondary diagnosis?	○ Yes ○ No ○ Unknown
Specify secondary diagnosis	_____
Outcome date	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Outcome	○ Discharged alive ○ Still hospitalised ○ Transfer to other facility ○ Death ○ Palliative discharge ○ Discharged against medical advice ○ Unknown

outcome_pathogen_testing

TEST	
Collection Date	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Biospecimen Type	○ Nasal/NP swab ○ Throat swab ○ Combined nasal/NP + throat swab ○ Sputum ○ BAL ○ ETA ○ Lesion swab ○ Urine ○ Faeces/rectal swab ○ Blood ○ Other
Please specify biospecimen type	_____

Lab test method	○ PCR ○ IgG ○ Culture ○ IgM ○ Antigen detection ○ 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?	☐ Yes - Positive (serologically confirmed) ☐ Yes - Positive (rapid diagnostic test) ☐ Yes - Negative (not-infected) ☐ Not tested

outcome_assessment

ASSESSMENT (Complete this section in full for each outcome assessment performed)	
Assessment Date	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Evaluation method	○ In person ○ Telephone
Assessment patient outcome	○ Discharged alive ○ Still hospitalised ○ Discharged against medical advice ○ Transfer to other facility ○ Death ○ Palliative discharge ○ 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	○ Yes ○ 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 Extened (GOS-E)	_____
Glasgow Outcome Scale Extened Pediatric Revision (GOS-E Peds) if patient is <= 16 years of age.	_____
Modified Rankin Scale (mRS) score	_____
MMSE score	_____
Neurological complications	☐ None ☐ Seziure disorder ☐ Motor impairment ☐ Psychological disturbance ☐ Congitive impairment ☐ Visual impairment ☐ 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 Congitive 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_]