NOVEL CORONAVIRUS (nCoV)

ACUTE RESPIRATORY INFECTION CLINICAL CHARACTERISATION DATA TOOL

DESIGN OF THIS CASE RECORD FORM (CRF)

This CRF is divided into a "CORE" form and a "DAILY" form for daily laboratory and clinical data.

Complete the CORE CRF + complete the DAILY CRF on the first day of hospital admission and on ICU admission, and daily upto discharge or death.

GENERAL GUIDANCE

- The CRF is designed to collect data obtained through examination, interview and review of hospital notes. Data may be collected retrospectively if the patient is enrolled after the admission date.
- **DO NOT INPUT ANY PATIENT IDENTIFIERS: THIS INCLUDES NAMES, ADDRESSES, DATE OF BIRTH OR PLACE OF BIRTH.**
- Step 1: Contact EDCARN@who.int to become a contributor to the nCoV global platform.
- Step 2: You will be contacted by ISARIC, platform manager, for assignment informational pack and instructions on how to use the REDCap nCoV platform.
- Step 3: Participant Identification Numbers will include a 3-digit country code, a 3 digit site code and a 4 digit participant number. Participant numbers should be assigned sequentially for each site beginning with 0001. In the case of a single site recruiting participants on different wards, or where it is otherwise difficult to assign sequential numbers, it is acceptable to assign numbers in blocks or incorporating alpha characters. E.g. Ward X will assign numbers from 0001 or A001 onwards and Ward Y will assign numbers from 5001 or B001 onwards. Enter the Participant Identification Number at the top of every page.
- Step 4: Data should be entered to the central electronic database. Printed paper CRFs may be used for later transfer of the data onto the electronic database. In the case of a participant transferring between sites, it is preferred to maintain the same Participant Identification Number across the sites. When this is not possible, space for recording the new number is provided.
- The contributor will:
    - Complete every line of every section, except for where the instructions say to skip a section based on certain responses.
    - Selections with square boxes (☐) are single selection answers (choose one answer only). Selections with circles (¢) are multiple selection answers (choose as many answers as are applicable)
    - Mark 'N/A' for any results of laboratory values that are not available, not applicable or unknown.
    - Avoid recording data outside of the dedicated areas. Sections are available for recording additional information.
    - If using paper CRFs, we recommend writing clearly in ink, using BLOCK-CAPITAL LETTERS. Place an (X) when you choose the corresponding answer. To make corrections, strike through (-------) the data you wish to delete and write the correct data above it. Please initial and date all corrections.
    - Please keep all of the sheets for a single participant together e.g. with a staple or participant-unique folder.
    - Please transfer all paper CRF data to the electronic database. All paper CRFs needs to be stored locally, do not send any forms with patient identifiable information to us via e-mail or post. All data should be transferred to the secure electronic database.
- If your site would like to collect data independently, establishment of locally hosted database is possible.
- Standard reports will be provided on regular basis to all contributors. Additional analysis for operational public health purposes will be determined by an independent WHO clinical advisory group.

CORE CASE RECORD FORM

CLINICAL INCLUSION CRITERIA
Suspected or proven acute novel Coronavirus (nCoV) infection as main cause for admission: ☐ YES ☐ NO

EPIDEMIOLOGICAL FACTORS	
In the 14 days before onset of illness had the patient any of the following:	
A history of travel to an area with documented cases of nCoV infection	☐ YES ☐ NO ☐ Unknown
Close contact* with a confirmed or probable case of nCoV infection, while that patient was symptomatic	☐ YES ☐ NO ☐ Unknown
Presence in a healthcare facility where nCoV infections have been managed	☐ YES ☐ NO ☐ Unknown
Presence in a laboratory handling suspected or confirmed nCoV samples	☐ YES ☐ NO ☐ Unknown
Direct contact with animals in countries where the nCoV is known to be circulating in animal populations or where human infections have occurred as a result of presumed zoonotic transmission	☐ YES ☐ NO ☐ Unknown

* Close contact' is defined as:
- Health care associated exposure, including providing direct care for novel coronavirus patients, e.g. health care worker, working with health care workers infected with novel coronavirus, visiting patients or staying in the same close environment of a novel coronavirus patient, or direct exposure to body fluids or specimens including aerosols.
- Working together in close proximity or sharing the same classroom environment with a novel coronavirus patient.
- Traveling together with novel coronavirus patient in any kind of conveyance.
- Living in the same household as a novel coronavirus patient.

CORE CASE RECORD FORM

DEMOGRAPHICS

Clinical centre name:_____ **Country:**_____

Enrolment date: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Ethnic group *(check all that apply)*: O Arab O Black O East Asian O South Asian O West Asian O Latin American O White

O Aboriginal/First Nations O Other: _____ ☐Unknown

Employed as a Healthcare Worker? ☐YES ☐NO ☐N/A

Employed in a microbiology laboratory? ☐YES ☐NO ☐N/A

Sex at Birth: ☐ Male ☐ Female ☐ Not specified

Estimated Age [___][___][___]years OR ___][___]months

Pregnant? ☐ YES ☐ NO ☐ Unknown ☐ N/A **If YES: Gestational weeks assessment:** [___][___] weeks

POST PARTUM? ☐YES ☐NO ☐ N/A *(if NO or N/A skip this section - go to INFANT)*

Pregnancy Outcome: ☐Live birth ☐Still birth **Delivery date:** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Baby tested for Mother's ARI infection? ☐YES ☐NO ☐N/A **If YES:** ☐Positive ☐Negative **Method:** ☐PCR ☐Other:_____

INFANT – Less than 1 year old? ☐YES ☐NO *(If NO skip this section)*

Birth weight: [___][___].[___]☐kg or ☐lbs ☐N/A

Gestational outcome: ☐ Term birth (≥37wk GA) ☐Preterm birth (<37wk GA) ☐N/A

Breastfed? ☐YES ☐NO ☐N/A **If YES:** ☐Currently breastfed ☐Breastfeeding discontinued at [___][___]weeks☐N/A

Appropriate development for age? ☐YES ☐NO ☐Unknown

Vaccinations appropriate for age/country? ☐YES ☐NO ☐Unknown ☐N/A

CORE CASE RECORD FORM

CO-MORBIDITIES			
Co-morbidities and risk factors – Charlson Index will be calculated for each patient at analysis.			
Chronic cardiac disease, including congenital heart disease *(not hypertension)*	☐YES ☐NO ☐N/A	Obesity *(as defined by clinical staff)*	☐YES ☐NO ☐N/A
Chronic pulmonary disease *(not asthma)*	☐YES ☐NO ☐N/A	Diabetes with complications	☐YES ☐NO ☐N/A
Asthma *(physician diagnosed)*	☐ YES ☐NO ☐N/A	Diabetes without complications	☐YES ☐NO ☐N/A
Chronic kidney disease	☐YES ☐NO ☐N/A	Rheumatologic disorder	☐YES ☐NO ☐N/A
Moderate or severe liver disease	☐YES ☐NO ☐N/A	Dementia	☐YES ☐NO ☐N/A
Mild liver disease	☐YES ☐NO ☐N/A	Malnutrition	☐YES ☐NO ☐N/A
Chronic neurological disorder	☐YES ☐NO ☐N/A	Smoking	☐YES ☐Never smoked ☐Former smoker
Malignant neoplasm	☐YES ☐NO ☐N/A	Other relevant risk factor ☐YES ☐NO ☐N/A	
Chronic hematologic disease	☐YES ☐NO ☐N/A	If yes, specify:_____	
AIDS / HIV	☐YES ☐NO ☐N/A	_____	

ONSET & ADMISSION

Onset date of first/earliest symptom: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Admission date at this facility: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Time of admission (24-hr format):[_H_][_H_]/[_M_][_M_]

Transfer from other facility? ☐YES-facility is a study site ☐YES-facility is not a study site ☐NO ☐N/A

If YES: **Name of transfer facility**:_____ ☐N/A

If YES: **Admission date at transfer facility** *(DD/MM/YYYY)*: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐N/A

If YES-Study Site: **Participant ID # at transfer facility:** ☐Same as above ☐Different: [___][___][___]–[___][___][___][___] ☐N/A

Travel in the 14 days prior to first symptom onset? ☐YES ☐NO ☐Unknown

If YES, *state location(s) & date(s):* Country:_____ City/Geographic area:_____

Return Date: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐ N/A *(more space at the end if required)*

Contact with animals, raw meat or insect bites in the 14 days prior to symptom onset?

☐YES ☐NO ☐Unknown ☐ N/A *If YES, complete the ANIMAL EXPOSURE section*

World Health Organization ISARIC

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

CORE CASE RECORD FORM

SIGNS AND SYMPTOMS AT HOSPITAL ADMISSION *(first available data at presentation/admission – within 24 hours)*

Temperature: [_][_][_].[_]☐☐°C *or* ☐☐°F **HR:** [_][_][_]beats per minute **RR:** [_][_]breaths per minute

Systolic BP: [_] [_] [_]mmHg **Diastolic BP:** [_][_][_]mmHg **Severe dehydration:** ☐YES ☐NO ☐Unknown

Sternal capillary refill time >2seconds ☐YES ☐NO ☐Unknown

Oxygen saturation: [_][_][_]% **On:** ☐Room air ☐Oxygen therapy ☐N/A

Admission signs and symptoms *(observed/reported at admission and associated with this episode of acute illness)*

History of fever	☐YES ☐NO ☐Unknown
Cough	☐YES ☐NO ☐ Unknown
with sputum production	☐YES ☐NO ☐ Unknown
bloody sputum/haemoptysis	☐YES ☐NO ☐ Unknown
Sore throat	☐YES ☐NO ☐ Unknown
Runny nose (Rhinorrhoea)	☐YES ☐NO ☐ Unknown
Ear pain	☐YES ☐NO ☐ Unknown
Wheezing	☐YES ☐NO ☐ Unknown
Chest pain	☐YES ☐NO ☐ Unknown
Muscle aches (Myalgia)	☐YES ☐NO ☐ Unknown
Joint pain (Arthralgia)	☐YES ☐NO ☐ Unknown
Fatigue / Malaise	☐YES ☐NO ☐ Unknown
Shortness of breath (Dyspnea)	☐YES ☐NO ☐ Unknown
Lower chest wall indrawing	☐YES ☐NO ☐ Unknown
Headache	☐YES ☐NO ☐ Unknown
Altered consciousness/confusion	☐YES ☐NO ☐ Unknown
Seizures	☐YES ☐NO ☐ Unknown
Abdominal pain	☐YES ☐NO ☐ Unknown
Vomiting / Nausea	☐YES ☐NO ☐ Unknown
Diarrhoea	☐YES ☐NO ☐ Unknown
Conjunctivitis	☐YES ☐NO ☐ Unknown
Skin rash	☐YES ☐NO ☐ Unknown
Skin ulcers	☐YES ☐NO ☐ Unknown
Lymphadenopathy	☐YES ☐NO ☐ Unknown
Bleeding (Haemorrhage)	☐YES ☐NO ☐ Unknown
If Bleeding: specify site(s):	_____ _____ _____

CORE CASE RECORD FORM

PATHOGEN TESTING:

Was pathogen testing done during this illness episode? ☐YES *(complete section)* ☐NO ☐N/A

Influenza : ☐ YES- Confirmed ☐ YES- Probable ☐ NO **If YES:** ☐ A/H3N2 ☐ A/H1N1pdm09 ☐ A/H7N9

☐ A/H5N1 ☐ A, not typed ☐ B ☐ Other:___________________________

Coronavirus: ☐ YES- Confirmed ☐ YES- Probable ☐ NO **If YES:** ☐ Novel CoV ☐ MERS CoV

☐ Other CoV: _____________________

RSV: ☐ YES- Confirmed ☐ YES- Probable ☐ NO

Adenovirus: ☐ YES- Confirmed ☐ YES- Probable ☐ NO

Bacteria: : ☐ Yes – confirmed : ☐ No

Other Infectious Respiratory diagnosis: ☐ YES- Confirmed ☐ YES- Probable ☐ NO

If yes Other Infectious Respiratory diagnosis, specify:____

Clinical pneumonia: ☐ YES ☐ NO ☐ Unknown **If NONE OF THE ABOVE: Suspected Non-infective:** ☐ YES ☐ N/A

Collection Date *(DD/MM/YYYY)*	**Biospecimen Type**	**Laboratory test Method**	**Result**	**Pathogen Tested/Detected**
___/___/20___	☐Nasal/NP swab ☐Throat swab ☐Combined nasal/NP+throat swab ☐Sputum ☐BAL ☐ETA ☐Urine ☐Feces/rectal swab ☐Blood ☐Other, *Specify:* ____________________	☐PCR ☐Culture ☐Other, *Specify:* ____________	☐Positive ☐Negative ☐N/A	_________________
___/___/20___	☐Nasal/NP swab ☐Throat swab ☐Combined nasal/NP+throat swab ☐Sputum ☐BAL ☐ETA ☐Urine ☐Feces/rectal swab ☐Blood ☐Other, *Specify:* ____________________	☐PCR ☐Culture ☐Other, *Specify:* ____________	☐Positive ☐Negative ☐N/A	_________________
___/___/20___	☐Nasal/NP swab ☐Throat swab ☐Combined nasal/NP+throat swab ☐Sputum ☐BAL ☐ETA ☐Urine ☐Feces/rectal swab ☐Blood ☐Other, *Specify:* ____________________	☐PCR ☐Culture ☐Other, *Specify:* ____________	☐Positive ☐Negative ☐N/A	_________________
___/___/20___	☐Nasal/NP swab ☐Throat swab ☐Combined nasal/NP+throat swab ☐Sputum ☐BAL ☐ETA ☐Urine ☐Faeces/rectal swab ☐Blood ☐Other, *Specify:* ____________________	☐PCR ☐Culture ☐Other, *Specify:* ____________	☐Positive ☐Negative ☐N/A	_________________
___/___/20___	☐Nasal/NP swab ☐Throat swab ☐Combined nasal/NP+throat swab ☐Sputum ☐BAL ☐ETA ☐Urine ☐Feces/rectal swab ☐Blood ☐Other, *Specify:* ____________________	☐PCR ☐Culture ☐Other, *Specify:* ____________	☐Positive ☐Negative ☐N/A	_________________

DAILY CASE RECORD FORM (complete one form on admission, one form on admission to ICU, and daily up to 14 days or until discharge or death if earlier)

DAILY ASSESSMENT FORM (on admission, on any admission to ICU, then daily) – complete every line

DATE OF ASSESSMENT *(DD/MM/YYYY):* [_D_][_D_]/[_M_][_M_]/[__2_][__0_][_Y_][_Y_]

Record the worst value between 00:00 to 24:00 on day of assessment (if Not Available write 'N/A'):

Current admission to ICU/ITU/IMC/HDU? ☐YES ☐NO ☐N/A

Record the worst value (within the previous 24 hours *(if Not Available write 'N/A'))*:

Done ☐YES ☐NO FiO_2 *(0.21-1.0)* [___].[___][___] or [___][___]L/min

Done ☐YES ☐NO SaO_2 [___][___][___]%

Done ☐YES ☐NO PaO_2 *at time of* FiO_2 *above* [___][___][___] ☐kPa *or* ☐mmHg

Done ☐YES ☐NO PaO_2 sample type: ☐ Arterial ☐ Venous ☐ Capillary ☐N/A

Done ☐YES ☐NO From same blood gas record as PaO_2 PCO_2 _____☐kPa *or* ☐mmHg

Done ☐YES ☐NO pH _____

Done ☐YES ☐NO HCO_3- _____mEq/L

Done ☐YES ☐NO Base excess _____ mmol/L

AVPU Alert [___] Verbal[___] Pain [___] Unresponsive[___]

Glasgow Coma Score (GCS / 15) [___][___]

Done ☐YES ☐NO Richmond Agitation-Sedation Scale (RASS) [___]

Done ☐YES ☐NO Riker Sedation-Agitation Scale (SAS**)** [___]

Done ☐YES ☐NO Systolic Blood Pressure [___][___][___]mmHg

Done ☐YES ☐NO Diastolic Blood Pressure [___][___][___]mmHg

Done ☐YES ☐NO Mean Arterial Blood Pressure [___][___][___]mmHg

Done ☐YES ☐NO Urine flow rate [___][___][___][___][___]mL/24 hours ☐ Check if estimated

Is the patient currently receiving, or has received (between 00:00 to 24:00 on day of assessment) *(apply to all questions in this section)*:

Non-invasive ventilation *(e.g. BIPAP, CPAP)*? ☐ YES ☐ NO ☐ N/A **Invasive ventilation?** ☐ YES ☐ NO ☐N/A

Extra corporeal life support (ECLS)? ☐ YES ☐ NO ☐ N/A **High-flow nasal canula oxygen therapy** ☐YES ☐NO ☐N/A

Dialysis/Hemofiltration? ☐YES ☐NO ☐N/A

Any vasopressor/inotropic support? ☐ YES ☐ NO *(if NO, answer the next 3 questions NO)* ☐N/A

Dopamine <5µg/kg/min OR Dobutamine OR milrinone OR levosimendan: ☐ YES ☐ NO

Dopamine 5-15µg/kg/min OR Epinephrine/Norepinephrine < 0.1µg/kg/min OR vasopressin OR phenylephrine:☐ YES ☐ NO

Dopamine >15µg/k/min OR Epinephrine/Norepinephrine > 0.1µg/kg/min: ☐ YES ☐ NO

Neuromuscular blocking agents? ☐ YES ☐ NO ☐ N/A **Inhaled Nitric Oxide?** ☐YES ☐NO ☐N/A

Tracheostomy inserted? ☐YES ☐NO ☐N/A **Prone positioning?** ☐ YES ☐ NO ☐ N/A

Other intervention or procedure: ☐ YES ☐ NO ☐ N/A If YES, Specify: _____

_____

DAILY CASE RECORD FORM (complete one form on admission, one form on admission to ICU, and daily up to 14 days or till discharge or death if earlier)

DAILY LABORATORY RESULTS (on admission, on any admission to ICU, then daily) – complete every line

DATE OF ASSESSMENT *(DD/MM/YYYY):* [_D_][_D_]/[_M_][_M_]/[__2_][__0_][_Y_][_Y_]

Record the worst value between 00:00 to 24:00 on day of assessment (if Not Available write 'N/A'):

Done ☐YES ☐NO **Haemoglobin** _____ ☐g/L *or* ☐g/dL

Done ☐YES ☐NO **WBC count** _____ ☐x10^9/L *or* ☐x10^3/µL

Done ☐YES ☐NO **Lymphocyte count** _____ _____ ☐cells/ µL

Done ☐YES ☐NO **Neutrophil count** _____ _____ ☐ cells/ µL

Done ☐YES ☐NO **Haematocrit** [___][___]%

Done ☐YES ☐NO **Platelets** _____ ☐x10^9/L *or* ☐x10^3/µL

Done ☐YES ☐NO **APTT/APTR** _____

Done ☐YES ☐NO **PT** _____ seconds

Done ☐YES ☐NO **INR**_____

Done ☐YES ☐NO **ALT/SGPT** _____ U/L

Done ☐YES ☐NO **Total Bilirubin** _____☐µmol/L *or* ☐mg/dL

Done ☐YES ☐NO **AST/SGOT** _____ U/L

Done ☐YES ☐NO **Glucose** _____☐mmol/L *or* ☐mg/dL

Done ☐YES ☐NO **Blood Urea Nitrogen (urea)** _____ ☐mmol/L *or* ☐mg/dL

Done ☐YES ☐NO **Lactate** _____☐mmol/L *or* ☐mg/dL

Done ☐YES ☐NO **Creatinine** _____ ☐µmol/L *or*☐mg/dL

Done ☐YES ☐NO **Sodium** [___][___][___][___] mEq/L

Done ☐YES ☐NO **Potassium** [___][___].[___] mEq/L

Done ☐YES ☐NO **Procalcitonin** [___][___].[___][___]ng/mL

Done ☐YES ☐NO **CRP**_[___][___][___].[___]_mg/L

Chest X-Ray performed? ☐YES ☐NO ☐N/A **IF Yes: Were infiltrates present?** ☐YES ☐NO ☐N/A

CORE CASE RECORD FORM

COMPLICATIONS: At any time during hospitalisation did the patient experience:							
Viral pneumonitis	☐ YES	☐ NO	☐N/A	**Cardiac arrest**	☐ YES	☐ NO	☐N/A
Bacterial pneumonia	☐ YES	☐ NO	☐N/A	**Bacteremia**	☐ YES	☐ NO	☐N/A
Acute Respiratory Distress Syndrome	☐ YES	☐ NO	☐N/A	**Coagulation disorder / Disseminated Intravascular Coagulation**	☐ YES	☐ NO	☐N/A
IF yes, specify: ☐ Mild ☐ Moderate ☐ Severe ☐ Unknown				**Anemia**	☐ YES	☐ NO	☐N/A
Pneumothorax	☐ YES	☐ NO	☐N/A	**Rhabdomyolysis / Myositis**	☐ YES	☐ NO	☐N/A
Pleural effusion	☐ YES	☐ NO	☐N/A	**Acute renal injury/ Acute renal failure**	☐ YES	☐ NO	☐N/A
Cryptogenic organizing pneumonia (COP)	☐ YES	☐ NO	☐N/A	**Gastrointestinal haemorrhage**	☐ YES	☐ NO	☐N/A
Bronchiolitis	☐ YES	☐ NO	☐N/A	**Pancreatitis**	☐ YES	☐ NO	☐N/A
Meningitis / Encephalitis	☐ YES	☐ NO	☐N/A	**Liver dysfunction**	☐ YES	☐ NO	☐N/A
Seizure	☐ YES	☐ NO	☐N/A	**Hyperglycemia**	☐ YES	☐ NO	☐N/A
Stroke / Cerebrovascular accident	☐ YES	☐ NO	☐N/A	**Hypoglycemia**	☐ YES	☐ NO	☐N/A
Congestive heart failure	☐ YES	☐ NO	☐N/A	**Other**	☐ YES	☐ NO	☐N/A
Endocarditis / Myocarditis / Pericarditis	☐ YES	☐ NO	☐N/A	**If yes specify**: _____			
Cardiac arrhythmia	☐ YES	☐ NO	☐N/A	_____			
Cardiac ischaemia	☐ YES	☐ NO	☐N/A				

CORE CASE RECORD FORM

TREATMENT: At ANY time during hospitalisation, did the patient receive/undergo:

ICU or High Dependency Unit admission? ☐YES ☐NO ☐N/A If YES, total duration: _____days

If yes, date of ICU admission: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐N/A

date of ICU discharge: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐N/A

Oxygen therapy? ☐YES ☐NO ☐N/A

Non-invasive ventilation? *(e.g. BIPAP, CPAP)* ☐YES ☐NO ☐N/A

Invasive ventilation *(Any)***?** ☐YES ☐NO ☐N/A If YES, total duration: _____days

Prone Ventilation? ☐YES ☐NO ☐N/A

Inhaled Nitric Oxide? ☐YES ☐NO ☐N/A

Tracheostomy inserted ☐YES ☐NO ☐N/A,

Extracorporeal support? ☐YES ☐NO ☐N/A

Renal replacement therapy (RRT) or dialysis? ☐YES ☐NO ☐N/A

Inotropes/vasopressors? ☐YES ☐NO ☐N/A

If YES: First/Start date: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐N/A

Last/End date: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐N/A

OTHER intervention or procedure *(please specify)***:** _____

MEDICATION: While hospitalised or at discharge, were any of the following administered?

Antiviral agent? ☐YES ☐NO ☐N/A **If YES:** ☐Ribavirin ☐Lopinavir/Ritonavir ☐Interferon alpha ☐Interferon beta

☐ Neuraminidase inhibitor ☐Other _____

Antibiotic? ☐YES ☐NO ☐N/A

Corticosteroid? ☐YES ☐NO ☐N/A **If YES, Route:** ☐Oral ☐Intravenous ☐Inhaled

If YES, please provide type and dose: _____

Antifungal agent? ☐YES ☐NO ☐N/A

CORE CASE RECORD FORM

OUTCOME

Outcome: ☐ Discharged alive ☐ Hospitalization ☐ Transfer to other facility ☐ Death

☐ Palliative discharge ☐ Unknown

Outcome date: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐ N/A

If Discharged alive:

Ability to self-care at discharge versus before illness: ☐ Same as before illness ☐ Worse ☐ Better ☐ N/A

If Discharged alive: Post-discharge treatment:

Oxygen therapy? ☐ YES ☐ NO ☐ N/A **Dialysis/renal treatment?** ☐ YES ☐ NO ☐ N/A

Other intervention or procedure? ☐ YES ☐ NO ☐ N/A

If YES: Specify *(multiple permitted):* _____

If Transferred: Facility name: _____ ☐ N/A

If Transferred: Is the transfer facility a study site? ☐ YES ☐ NO ☐ N/A

If a Study Site: Participant ID# at new facility: ☐ Same as above ☐ Different: [___][___][___] – [___][___][___][___] ☐N/A

CORE CASE RECORD FORM

TRAVEL: Did the patient travel in the 14 days prior to first symptom onset? If > 1 *location & date list:*
Country:_____ City/Geographic area: _____ Return Date *(DD/MM/20YY):* ____ /____ /20_____
Country:_____ City/Geographic area: _____ Return Date *(DD/MM/20YY):* ____ /____ /20_____
Country:_____ City/Geographic area: _____ Return Date *(DD/MM/20YY):* ____ /____ /20_____

ANIMAL EXPOSURES: Did the patient have contact with live/dead animals, raw meat or insect bites in the 14 days prior to first symptom onset? ☐YES ☐NO ☐N/A If yes, *Complete each line below.*
If YES, specify the animal/insect, type of contact and date of exposure (DD/MM/YYYY) ⬇ *here:*

Bird/Aves (e.g. chickens, turkeys, ducks)	☐YES ☐NO ☐N/A	
Bat	☐YES ☐NO ☐N/A	
Livestock (e.g. goats, cattle, camels)	☐YES ☐NO ☐N/A	
Horse	☐YES ☐NO ☐N/A	
Hare/ Rabbit	☐YES ☐NO ☐N/A	
Pigs	☐YES ☐NO ☐N/A	
Non-human primates	☐YES ☐NO ☐N/A	
Rodent (e.g. rats, mice, squirrels)	☐YES ☐NO ☐N/A	
Insect or tick bite (e.g. tick, flea, mosquito)	☐YES ☐NO ☐N/A	
Reptile / Amphibian	☐YES ☐NO ☐N/A	
Domestic animals living in his/her home (e.g. cats, dogs, other)	☐YES ☐NO ☐N/A	
Animal feces or nests	☐YES ☐NO ☐N/A	
Sick animal or dead animal	☐YES ☐NO ☐N/A	
Raw animal meat / animal blood	☐YES ☐NO ☐N/A	
Skinned, dressed or eaten wild game	☐YES ☐NO ☐N/A	
Visit to live animal market, farm or zoo	☐YES ☐NO ☐N/A	
Participated in animal surgery or necropsy	☐YES ☐NO ☐N/A	
Other animal contacts:	☐YES ☐NO ☐N/A	