

MODULE 3: OUTCOME CASE REPORT FORM

| TREATMENT: At ANY time during hospitalisation, did the patient receive/undergo: | |
|---|--|
| Any Oxygen therapy? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown | If YES, total duration: _____ days <input type="radio"/> Unknown |
| Maximum O ₂ flow volume: <input type="radio"/> <2 L/min <input type="radio"/> 2-5 L/min <input type="radio"/> 6-10 L/min <input type="radio"/> 11-15 L/min <input type="radio"/> >15 L/min | |
| Non-invasive ventilation? (Any) <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown | If YES, total duration: _____ days <input type="radio"/> Unknown |
| Invasive ventilation? (Any) <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown | If YES, total duration: _____ days <input type="radio"/> Unknown |
| High flow nasal oxygen <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown | If YES, total duration: _____ days <input type="radio"/> Unknown |
| Prone Positioning? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown | |
| Inhaled Nitric Oxide? <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 | |
| Extracorporeal support (ECMO)? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown | If YES, total duration: _____ days <input type="radio"/> Unknown |
| Renal replacement therapy (RRT) or dialysis? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown | |
| Inotropes/vasopressors? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown | |
| ICU or High Dependency Unit admission? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown | If YES, total duration: _____ days <input type="radio"/> Unknown |
| If YES, date of ICU admission: [D][D]/[M][M]/[2][0][Y][Y] <input type="radio"/> Unknown | |
| date of ICU discharge: [D][D]/[M][M]/[2][0][Y][Y] <input type="radio"/> Unknown | |

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| COMPLICATIONS: At any time during hospitalisation did the patient experience: (<i>Unk = Unknown</i>) | | | |
|--|--|--|--|
| Viral pneumonia/pneumonitis | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk | Meningitis / Encephalitis | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk |
| Bacterial pneumonia | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk | Bacteremia | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk |
| Acute Respiratory Distress Syndrome | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk | Coagulation disorder / DIC | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk |
| Pneumothorax | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk | Pulmonary Embolism | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk |
| Pleural effusion | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk | Deep Vein Thrombosis | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk |
| Cryptogenic organizing pneumonia (COP) | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk | Other thromboembolism (not PE or DVT) | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk |
| Bronchiolitis | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk | Anemia | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk |
| Cardiac arrest | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk | Rhabdomyolysis / Myositis | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk |
| Myocardial infarction | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk | Acute renal injury/ Acute renal failure | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk |
| Cardiac ischaemia | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk | Gastrointestinal haemorrhage | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk |
| Cardiac arrhythmia | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk | Pancreatitis | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk |
| Myocarditis / Pericarditis | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk | Liver dysfunction | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk |
| Endocarditis | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk | Hyperglycemia | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk |
| Cardiomyopathy | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk | Hypoglycemia | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk |
| Congestive heart failure | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk | Other <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk If YES, specify: _____ | |
| Seizure | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk | | |
| Stroke / Cerebrovascular accident | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk | | |

| DIAGNOSTICS |
|--|
| <p>Section 1: RESPIRATORY VIRUS PCR TESTING</p> <p>SARS-CoV-2 (COVID-19): <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done <input type="radio"/> Unknown</p> <p>Was other pathogen testing done during this illness episode? <input type="radio"/> YES (<i>complete section</i>) <input type="radio"/> NO <input type="radio"/> Unknown</p> <p>Influenza : <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done <input type="radio"/> Unknown</p> <p>If Positive: <input type="radio"/> A-not typed <input type="radio"/> A/H3N2 <input type="radio"/> A/H1N1pdm09 <input type="radio"/> A/H7N9 <input type="radio"/> A/H5N1 <input type="radio"/> B <input type="radio"/> Other: _____ .. <input type="radio"/> Unk</p> <p>Respiratory Syncytial Virus (RSV): <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done <input type="radio"/> Unknown</p> <p>Adenovirus: <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done <input type="radio"/> Unknown</p> |
| <p>Section 2: BACTERIAL TESTING</p> <p>Bacteria: <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done If Positive, specify: _____ <input type="radio"/> Unknown</p> <p>Other pathogen/s detected: <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown If YES, specify all: _____ <input type="radio"/> Unknown</p> |
| <p>Section 3: RADIOLOGY</p> <p>Clinical pneumonia diagnosed? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown</p> <p>Chest X-Ray performed? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown If Yes: Were infiltrates present? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown</p> <p>CT performed? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown If Yes: Were infiltrates present? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown</p> |

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MEDICATION (continued):

 ANTIBIOTIC? YES NO Unknown **If yes, specify all:**

Agent 1: _____ Date commenced [] [] / [] [] / [] [] [] [] Duration: _____ days Unk
 Agent 2: _____ Date commenced [] [] / [] [] / [] [] [] [] Duration: _____ days Unk
 Agent 3: _____ Date commenced [] [] / [] [] / [] [] [] [] Duration: _____ days Unk

 CORTICOSTEROID? YES NO Unknown

 If YES: Dexamethasone? YES NO Unknown

If YES, check all that apply:

 6mg once per day (od)? YES NO Unknown **If YES, Route:** Oral Intravenous Unk

 If YES, Date commenced [] [] / [] [] / [] [] [] [] Duration: _____ days Unk

 other dose or frequency? YES NO Unknown **If YES, Route:** Oral Intravenous Unk

 If YES, Date commenced [] [] / [] [] / [] [] [] [] Duration: _____ days Unk

 If YES: Other corticosteroid? YES NO Unknown

 If YES: Which steroid: Prednisolone Hydrocortisone Methylprednisolone Other

 Route: Oral Intravenous Unk

 ANTICOAGULATION? YES NO Unk

If YES: Agent: _____

 Route: Subcutaneous Intravenous (IV) Unk

 Indication: therapeutic (treatment of DVT/PE) enhanced prophylaxis for COVID-19 routine inpatient prophylaxis Unk

 ANTIFUNGAL AGENT? YES NO Unk

 OTHER treatments administered for COVID-19 including experimental or compassionate use? YES NO Unk

If YES, specify agent and timing of administration:

Agent 1: _____

 Date commenced [] [] / [] [] / [] [] [] [] Unk Duration: _____ days Unk

Agent 2: _____

 Date commenced [] [] / [] [] / [] [] [] [] Unk Duration: _____ days Unk

Agent 3: _____

 Date commenced [] [] / [] [] / [] [] [] [] Unk Duration: _____ days Unk

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OUTCOME

Was patient diagnosed with Covid-19? YES NO UnknownIf yes, was the diagnosis based on: Laboratory confirmation clinical assessment

Has a variant of concern (VOC) or variant of interest (VOI) been identified in this patient?

-
- Unknown
-
-
- Yes, a variant not listed below
-
-
- Alpha - B.1.1.7, identified in UK Sept 2020
-
-
- Beta - B.1.351, identified in South Africa May 2020
-
-
- Gamma - P.1, identified in Brazil Nov 2020
-
-
- Delta - B.1.617.2, identified in India Oct 2020
-
-
- Epsilon - B.1.427/B.1.429, identified in USA Mar 2021
-
-
- Zeta - P.2, identified in Brazil Apr 2020
-
-
- Eta - B.1.525, identified in Multiple Countries Dec 2020
-
-
- Theta - P.3, identified in Philippines Jan 2021
-
-
- Iota - B.1.526, identified in USA Nov 2020
-
-
- Kappa - B.1.617.1, identified in India Oct 2020
-
-
- Lambda - C.37, identified in Peru Dec 2020

*Please check the REDCAP database for variants not listed above. New variants will be added to the database as they are identified.*Outcome: Discharged alive Hospitalised Transfer to other facility Death Palliative discharge UnknownOutcome date: [_] [_] / [_ M] [_ M] / [_ 2] [_ 0] [_ Y] [_ Y] Unknown

If alive at outcome date:

Ability to self-care at discharge versus before illness: Same as before illness Worse Better UnknownPost-discharge treatment: Oxygen therapy? YES NO UnknownOngoing health care needs relating to this admission for COVID-19: YES NO UnknownOngoing health care needs NOT related to COVID episode: YES NO UnknownMedically fit for discharge (COVID-19 resolved) but remains in hospital for other reason (e.g. awaiting suitable care in community, resident in long term health care or mental health facility): YES NO Unknown