## MODULE 1: PRESENTATION/ADMISSION CASE REPORT FORM

### CLINICAL INCLUSION CRITERIA

**Suspected or confirmed novel coronavirus (COVID-19) infection:**  
- **YES**
- **NO**

### DEMOGRAPHICS

- **Clinical centre name:**
- **Country:**
- **Enrolment date /first COVID-19 assessment date:**
- **Ethnic group** *(check all that apply)*:  
  - Arab
  - Black
  - East Asian
  - South Asian
  - West Asian
  - Latin American
  - White
  - Aboriginal/First Nations
  - Other: ________________________
  - Unknown
- **Employed as a Healthcare Worker?**  
  - **YES**
  - **NO**
  - **Unknown**
- **Employed in a microbiology laboratory?**  
  - **YES**
  - **NO**
  - **Unknown**
- **Sex at Birth:**  
  - Male
  - Female
  - Not specified/Unknown
  - Age: [___][___][___] years OR [___][___] months
- **Pregnant?**  
  - **YES**
  - **NO**
  - **Unknown**
  - If YES:
    - **Gestational weeks assessment:** [___][___] weeks
- **POST PARTUM (within 6 weeks of delivery)?**  
  - **YES**
  - **NO**
  - **Unknown** *(if NO or Unknown skip this section)*
- **Delivery Outcome:**  
  - Live birth
  - Still birth
  - **Delivery date:**
- **Baby tested for COVID-19/SARS-CoV-2 infection?**  
  - **YES**
  - **NO**
  - **Unknown**
  - If YES, result of test:
    - Positive
    - Negative
    - Unknown *(If Positive, complete a separate CRF for baby)*
- **INFANT – Less than 1 year old?**  
  - **YES**
  - **NO** *(If NO skip this section)*
  - **Birth weight:** [___][___][___] kg or [___] lbs
  - **Gestational outcome:**  
    - Term birth (≥37wk GA)
    - Preterm birth (<37wk GA)
    - **Unknown**
  - **Breastfed?**  
    - Currently breastfeeding
    - Breastfeeding discontinued
    - **NO**
    - **Unknown**
  - **Vaccinations appropriate for age/country?**  
    - **YES**
    - **NO**
    - **Unknown**

### ONSET & ADMISSION

- **Onset date of first/earliest symptom:**
- **Most recent presentation/admission date at this facility:**

### RE-ADMISSION

- **Was the patient admitted previously or transferred from any other facility during this illness episode?**
  - **YES**-admitted previously to this facility
  - **YES**-transferred from other facility
  - **NO**
  - **Unknown**
- **Has this patient’s data been previously collected under a different patient number?**
  - **YES**
  - **NO**
  - **Unknown**
  - If YES, Participant Identification number (PIN):
  - **Previous participant ID:**
  - **Unknown**
- **Number of re-admissions:**
  - **record as a new patient for each re-admission**
- **Is the patient being re-admitted with or due to COVID-19?** *(Please only add re-admission episodes for COVID related complications or patients remaining positive). Assign new subject ID*
  - **YES**
  - **NO**
  - **Unknown**
  - **Please provide reason for readmission:**
MODULE 1: PRESENTATION/ADMISSION CASE REPORT FORM

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

Temperature: [____][____][____][____]°C or O°F

HR: [____][____][____]beats/minute  RR: [____][____]breaths/minute

Systolic BP: [____][____][____]mmHg  Diastolic BP: [____][____][____]mmHg

Oxygen saturation: [____][____][____]%  On: ORoom air  O Oxygen therapy  O Unknown

Sternal capillary refill time >2 sec.  O YES  O NO  O Unknown

History of fever

Cough  OYES - non-productive  OYES - productive

Sore throat  OYES - with haemoptysis  ONO

Runny nose (rhinorrhoea)

Wheezing  ONO

Shortness of breath

Lower chest wall indrawing

Chest pain  ONO

Conjunctivitis

Lymphadenopathy

Headache

Loss of smell (Anosmia)

Loss of taste (Ageusia)

Seizures

Fatigue / Malaise

Anorexia

Altered consciousness/confusion

Muscle aches (myalgia)

Joint pain (arthralgia)

Inability to walk

Abdominal pain

Diarrhoea

Vomiting / Nausea

Skin rash

Bleeding (Haemorrhage)

If YES, specify site(s):_____________________________________

If YES, specify:____________________________________________

If YES, specify:____________________________________________

IF YES, please specify________________________

O Other symptom(s)

VACCINATIONS

COVID-19 vaccination:

Date of first vaccine

Type of first vaccine:
Pfizer/BioNTech  OAstraZeneca Oxford (Covishield in India)  OMModerna  ONovavax

Janssens (Johnson & Johnson)  OSinopharm  OSinovac  OSputnik V  OCovaxin  OCansinoBIO

Unk

OOther, please specify________________________

Date of second vaccine

Type of second vaccine:
Pfizer/BioNTech  OAstraZeneca/University of Oxford (Covishield in India)  OMModerna  ONovavax

Janssens (Johnson & Johnson)  OSinopharm  OSinovac  OSputnik V  OCovaxin  OCansinoBIO

Unk

OOther, please specify________________________

Date of third vaccine

Type of third vaccine:
Pfizer/BioNTech  OAstraZeneca/University of Oxford (Covishield in India)  OMModerna  ONovavax

Janssens (Johnson & Johnson)  OSinopharm  OSinovac  OSputnik V  OCovaxin  OCansinoBIO

Unk

OOther, please specify________________________

Influenza vaccination within the last 6 months:  OYES  ONO  OUnknown

Date of influenza vaccine

ISARIAC COVID-19 CORE CASE RECORD FORM 05JUL21

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# MODULE 1: PRESENTATION/ADMISSION CASE REPORT FORM

**PRE-ADMISSION MEDICATION** *(taken within 14 days prior to admission/presentation at healthcare facility)*

<table>
<thead>
<tr>
<th>Medication Type</th>
<th>YES</th>
<th>NO</th>
<th>Unknown</th>
<th>If YES, Oral</th>
<th>Inhaled</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steroids</td>
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<tr>
<td>Other immunosuppressant agents (not oral steroids)</td>
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<tr>
<td>Antibiotics</td>
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<tr>
<td>Antivirals</td>
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<tr>
<td>Other targeted COVID-19 Medications</td>
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</tbody>
</table>

**CO-MORBIDITIES AND RISK FACTORS** *(existing prior to admission and ongoing)*

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
<th>Unknown</th>
<th>If YES, Most recent CD4 count:</th>
<th>HIV</th>
<th>ART</th>
<th>if NOT ART</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic cardiac disease <em>(not hypertension)</em></td>
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<tr>
<td>Hypertension</td>
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<tr>
<td>Chronic pulmonary disease <em>(not asthma)</em></td>
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<tr>
<td>Asthma <em>(physician diagnosed)</em></td>
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<tr>
<td>Chronic kidney disease</td>
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<tr>
<td>Obesity <em>(as defined by clinical staff)</em></td>
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<tr>
<td>Moderate or severe liver disease</td>
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<tr>
<td>Mild liver disease</td>
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<tr>
<td>Asplenia</td>
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<tr>
<td>Chronic neurological disorder</td>
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<tr>
<td>Malignant neoplasm</td>
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