

# ISARIC CRF\_NAME CRF

## DESIGN OF THIS CASE REPORT FORM (CRF)

This CRF is set up in modules to be used for recording data on crf\_name. 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
FOLLOW-UP FORM				(COMPLETE)	
WITHDRAWAL FORM				(COMPLETE)	

## GENERAL GUIDANCE

- Contact ISARIC Global Support Centre at [data@isaric.org](mailto: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

## INCLUSION CRITERIA

Participant Identification Number (PIN): _____	Date of Enrolment [ _D_ ][ _D_ ]/[ _M_ ][ _M_ ]/[ _Y_ ][ _Y_ ][ _Y_ ][ _Y_ ]
Site name _____	

### INCLUSION CRITERIA

Proven or suspected hantavirus infection  Yes  No

High suspicion of exposure to hantavirus  Yes  No

If Yes: Which of the following is the individual proven/suspected of having or exposed to?

- Andes virus infection (hantavirus)  
 Other  
 Unknown

\_\_\_\_\_

## CONSENT

### CONSENT - As a research professional I certifying that consent has been documented

Consent has been obtained for the collection of samples including DNA:

- Yes  
 No  
 N/K

Consent options  
 (select all to which the patient agreed):

- Data and samples may be used for other unrelated ethically approved research  
 Data and samples can be used to manufacture tests, treatments, or other products, including commercial products  
 De-identified data and results of analyses, can be shared with other scientists, including those in other countries  
 Participant may be contacted by the investigators to be invited to participate in future work, including research studies

## PRESENTATION

ONSET & PRESENTATION			
Initial clinical and PCR status at presentation	<input type="radio"/> Exposed / asymptomatic / PCR negative <input type="radio"/> PCR positive / asymptomatic <input type="radio"/> PCR positive / Symptomatic disease <input type="radio"/> Unknown	Onset date of first / earliest symptom	[ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] [ _ ]
Date of first clinical consultation	[ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] [ _ ]	Most recent presentation/admission date at this facility	[ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] [ _ ]
Admitted to hospital	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Reason for hospitalisation	<input type="radio"/> Infection of interest <input type="radio"/> Other

DEMOGRAPHICS			
Is the date of birth known?	<input type="radio"/> Yes <input type="radio"/> No		
If Yes: Date of birth	[ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] [ _ ]	If No: Age	<input type="radio"/> Years <input type="radio"/> Months <input type="radio"/> Days
Sex at birth	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Not specified/Unknown <input type="radio"/> Other	Gender	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Non-binary <input type="radio"/> Unknown <input type="radio"/> Other
Weight		Height	
_____		_____	
<input type="radio"/> kg <input type="radio"/> lb		<input type="radio"/> cm <input type="radio"/> in	
Employed as a healthcare worker	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes:	
Patient facing	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Exposed to biological samples	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Does the patient practise any of these professions or a profession related to their infection	<input type="radio"/> Abattoir Worker <input type="radio"/> Beef Cattle Farm Worker <input type="radio"/> Dairy Farm Worker <input type="radio"/> Healthcare Worker <input type="radio"/> Live bird market worker <input type="radio"/> Other live animal market worker <input type="radio"/> Poultry Farm Worker <input type="radio"/> Poultry culler <input type="radio"/> Swine farm worker <input type="radio"/> Veterinarian <input type="radio"/> Other	Primary location of occupation	<input type="radio"/> Home-working or unemployed <input type="radio"/> Indoors-office/health/education/hospitality/business/homes <input type="radio"/> Indoors-factory <input type="radio"/> Outdoors-animal contact (vet, animal farmer, abattoir worker) <input type="radio"/> Outdoors-agriculture/forestry/fisheries <input type="radio"/> Outdoors-construction/industrial/mining <input type="radio"/> Armed Forces <input type="radio"/> Student <input type="radio"/> Unknown <input type="radio"/> Other
Patient's city of residence	<input type="radio"/> Same as health care facility <input type="radio"/> Different from health care facility <input type="radio"/> Unknown		

**EXPOSURE HISTORY IN PREVIOUS 6 WEEKS**

Did the patient travel outside of their home region in the past 6 Weeks?  Yes  
 No  
 Unknown

History of exposure or contact with suspected or confirmed human case of same pathogen?  Yes  
 No  
 Unknown If Yes:

Contact setting  MV Hondius  
 Household  
 Community/social  
 Healthcare facility  
 Occupational/workplace  
 Sexual contact  
 Air travel/flight  
 Other  
 Unknown

Date of first contact with suspected or confirmed case [ \_ ] [ \_ ] [ \_ ] / [ \_ ] [ \_ ] [ \_ ] / [ \_ ] [ \_ ] [ \_ ] [ \_ ] [ \_ ] [ \_ ]

Date of last contact with suspected or confirmed case [ \_ ] [ \_ ] [ \_ ] / [ \_ ] [ \_ ] [ \_ ] / [ \_ ] [ \_ ] [ \_ ] [ \_ ] [ \_ ] [ \_ ]

Exposure continuous or repeated  Continuous  
 Repeated  
 Both  
 Unknown

**EXPOSURE TO CONFIRMED OR SUSPECTED CASE ON BOARD**

Shared cabin with confirmed or suspected case  Yes  
 No  
 Unknown

Shared bathroom facilities with confirmed or suspected case  Yes  
 No  
 Unknown

Shared meals with confirmed or suspected case  Yes  
 No  
 Unknown

Participated in social activities with confirmed or suspected case  Yes  
 No  
 Unknown

Participated in shared shore/off-boat excursions with confirmed or suspected case  Yes  
 No  
 Unknown

Worked or spent prolonged time in the same enclosed area as confirmed or suspected case  Yes  
 No  
 Unknown

Cabin number (if known) \_\_\_\_\_

Deck/floor of cabin \_\_\_\_\_

Date of leaving MV Hondius [ \_ ] [ \_ ] [ \_ ] / [ \_ ] [ \_ ] [ \_ ] / [ \_ ] [ \_ ] [ \_ ] [ \_ ] [ \_ ] [ \_ ]

**HOUSEHOLD EXPOSURE**

Any unwell household members in the 6 weeks prior to the admission of case?  Yes  
 No  
 Unknown

If Yes: Which system(s) are affected? (tick all that apply)

Respiratory  
 Gastrointestinal  
 Cardiovascular  
 Central Nervous system  
 Peripheral Nervous system  
 Mucocutaneous  
 Ocular  
 Unknown  
 Other

Have household members had any contact with a confirmed case of the same infection?  Yes  
 No  
 Unknown

HANTAVIRUS-SPECIFIC EXPOSURES			
Exposure to rodent-contaminated environments before boarding the vessel (e.g. exposure in Argentina, shared visit to rubbish dump for birdwatching, contact with areas potentially contaminated by rodents)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Rodent sighting or exposure on board the vessel	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Direct contact with rodents	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes:	
Rodents type	<input type="checkbox"/> Rats <input type="checkbox"/> Mice	Specify type of contact	<input type="checkbox"/> Hunting <input type="checkbox"/> Preparing <input type="checkbox"/> Handling <input type="checkbox"/> Consumption (unprocessed / undercooked / raw) <input type="checkbox"/> Trading <input type="checkbox"/> Animal faeces or nests <input type="checkbox"/> Sick or dead animal <input type="checkbox"/> Unknown <input type="checkbox"/> Other

OTHER ANIMAL EXPOSURES			
Other animal exposures	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
Contact with wildlife	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Wildlife type	<input type="checkbox"/> Bats <input type="checkbox"/> Other _____
Any insect or arthropod bites (eg. mosquitoes, ticks)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
Other animal contact not listed above	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Specify animal contacts not listed above	_____

WATER / ENVIRONMENTAL EXPOSURES			
Patient swam or bathed in pools, ponds, or rivers	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Exposure to flood water/stagnant water bodies or contaminated water	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown

CO-MORBIDITIES AND RISK FACTORS: Existing prior to this current illness and is ongoing			
Chronic cardiac disease (not hypertension)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes:	
Myocardial infarction	<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
Hypertension	<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	<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	If Yes: Type of liver disease	<input type="radio"/> Mild <input type="radio"/> Moderate or severe <input type="radio"/> Unknown
Chronic kidney disease	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Stage of chronic kidney disease	<input type="radio"/> Stage 1 <input type="radio"/> Stage 2 <input type="radio"/> Stage 3a <input type="radio"/> Stage 3b <input type="radio"/> Stage 4 <input type="radio"/> Stage 5 <input type="radio"/> Unknown
HIV	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
Is the patient on anti-retroviral therapy (ART)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Specify ART	_____
If HIV positive: CD4 count date	[ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ]	If HIV positive: Most recent CD4 count (cells/ÅµL)	_____
If HIV positive: Is HIV viral load detectable	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Most recent HIV viral load (copies/mL)	_____
HIV viral load date	[ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ]		
Tuberculosis	<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
Rheumatologic 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 haematologic disease	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Obesity	<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		
Diabetes mellitus	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes:	
Diabetes mellitus type	<input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational diabetes <input type="radio"/> Unknown	End organ damage from diabetes	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Ever smoked	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Smoking status	<input type="radio"/> Current smoker <input type="radio"/> Former Smoker
Transplant recipient	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Specify transplanted organ(s)	<input type="checkbox"/> Lung <input type="checkbox"/> Heart <input type="checkbox"/> Kidney <input type="checkbox"/> Liver <input type="checkbox"/> Bone <input type="checkbox"/> Hematopoietic stem cell <input type="checkbox"/> Other _____

Primary immunodeficiency <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Chemotherapy <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Radiation therapy <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Long term or high-dose corticosteroid therapy <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
Other relevant comorbidity(s) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: _____	
Active Hepatitis C <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Active Hepatitis B <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	

### MEDICAL HISTORY

Is the patient known to have had previous infection(s) with this pathogen? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: _____	
Was the patient ever hospitalised in a previous episode of the same infection? <input type="radio"/> Yes-admitted to hospital or ICU <input type="radio"/> No <input type="radio"/> Unknown	When did the previous episode begin? [ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] [ _ ]	
When did the previous episode end? [ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] [ _ ]	Was the previous episode confirmed by laboratory testing? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	

### MEDICATION PRIOR TO THIS ADMISSION / PRESENTATION

Antiviral <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: _____	
Antiviral <input type="checkbox"/> Favipiravir <input type="checkbox"/> Ribavirin <input type="checkbox"/> Other _____	Antiviral start date [ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] [ _ ]	
Number of days antivirals taken _____		
Corticosteroid <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: _____	
Corticosteroid <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Prednisolone/ Prednisone <input type="checkbox"/> Other _____	Corticosteroid start date [ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] [ _ ]	
Number of days corticosteroid taken _____	Dose of corticosteroid _____	

Antibiotics	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Antibiotics	<input type="checkbox"/> Azithromycin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Vancomycin <input type="checkbox"/> Other _____
NSAIDs	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes:	
NSAIDs	<input type="checkbox"/> Acetylsalicylic acid (Aspirin) <input type="checkbox"/> Diclofenac <input type="checkbox"/> Other _____	total NSAID dose mg/day	_____ Duration of NSAID use (days) _____
Analgesics/antipyretics (non-NSAID)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Select Analgesics/antipyretics (non-NSAID)	<input type="checkbox"/> Paracetamol (Acetaminophen) <input type="checkbox"/> Metamizole (Dipyrone) <input type="checkbox"/> Other
Opioids	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
Intravenous (parenteral) fluids	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes:	
Intravenous fluid type	<input type="checkbox"/> 0.9% Sodium Chloride (Normal Saline) <input type="checkbox"/> Hartmann's Solution / Ringer's Lactate <input type="checkbox"/> Other _____	Total intravenous fluid volume in the previous 24 hours (mL)	_____
Indication / reason	<input type="checkbox"/> Shock <input type="checkbox"/> High/rising haematocrit <input type="checkbox"/> Anorexia <input type="checkbox"/> Persistent vomiting <input type="checkbox"/> Other		
Antihypertensive medication	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Select Antihypertensive medication	<input type="checkbox"/> Diuretics <input type="checkbox"/> ACE inhibitors <input type="checkbox"/> ARBs <input type="checkbox"/> Calcium channel blockers <input type="checkbox"/> Beta-blockers

**VACCINATION**

Vaccinated for COVID-19 (ever)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Date of most recent COVID-19 vaccine	[ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ]
Vaccinated for seasonal influenza (ever)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Date of most recent seasonal influenza vaccine	[ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ]
Vaccinated for pneumococcal disease	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Date of most recent pneumococcal disease vaccine	[ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ]
Vaccinated for shingles (ever)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Date of most recent shingles vaccine	[ _ ] [ _ ] [ _ ] / [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ]

PREGNANCY PRESENTATION			
Pregnant	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
If No, Unknown: Post-partum (within 6 weeks of delivery)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Gestational weeks at presentation	_____
Delivery date	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]	Pregnancy outcome	<input type="radio"/> Livebirth (even if infant died after birth) <input type="radio"/> Miscarriage (<22 weeks) <input type="radio"/> Termination by choice <input type="radio"/> Termination - ultrasound abnormality <input type="radio"/> Termination - other/unknown reason <input type="radio"/> Stillbirth (intra-uterine / intrapartum death from 22 gest weeks) <input type="radio"/> Ectopic pregnancy <input type="radio"/> Unknown
Breastfeeding	<input type="radio"/> Yes-currently breastfeeding <input type="radio"/> Yes-breastfeeding discontinued <input type="radio"/> No <input type="radio"/> Unknown	How long did breastfeeding last? (weeks)	_____
Baby tested for mother's infection of interest	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Specify test result from mother's infection of interest	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown

INFANT (<12 MONTHS) OR POST-PARTUM BIRTH (<6 WEEKS)			
Birth weight	_____	Preterm birth (< 37wk GA)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Breastfed	<input type="radio"/> Yes-currently breastfeeding <input type="radio"/> Yes-breastfeeding discontinued <input type="radio"/> No <input type="radio"/> Unknown	If Yes-breastfeeding discontinued: How long did breastfeeding last? (weeks)	_____

**DAILY**

DAILY ASSESSMENT	
DATE OF ASSESSMENT [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ]	Current level of care <input type="radio"/> Home confinement <input type="radio"/> Admitted to hospital ward for isolation only <input type="radio"/> Admitted to hospital ward for clinical care and/or treatment (and probably isolation) <input type="radio"/> High dependency unit (HDU) <input type="radio"/> Intensive care unit (ICU) <input type="radio"/> Unknown

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? <input type="radio"/> Yes <input type="radio"/> No	If Yes, complete the form:
Highest temperature _____ °C °F	Heart Rate (bpm) _____
Systolic BP (mmHg) _____	Diastolic BP (mmHg) _____
Oxygen saturation at room air (no oxygen support) (%) _____	Capillary refill time >2 seconds <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
ACVPU <input type="radio"/> Alert <input type="radio"/> Confusion <input type="radio"/> Verbal <input type="radio"/> Pain <input type="radio"/> Unresponsive	Glasgow Coma Score (GCS / 15) _____
Richmond Agitation-Sedation Scale (RASS) _____	Urine output (mL/day) _____

SYMPTOMS: Indicate if experienced between 00:00 to 24:00 on day of assessment.	
Did the patient report symptoms on this date? <input type="radio"/> Yes <input type="radio"/> No	If Yes, complete the form:
Fever <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Chills or rigors <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Weakness <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
Back Pain <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Neck Pain <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Cough <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Cough type <input type="radio"/> Non Productive <input type="radio"/> Productive <input type="radio"/> Haemoptysis <input type="radio"/> Unknown
Shortness of breath <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Chest pain <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	Skin rash <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 <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	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	Urinary retention <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Increased urination (polyuria) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Bleeding (haemorrhage) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes:	
Severe bleeding (requires intervention) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Specify bleeding site(s)	<input type="checkbox"/> GI tract <input type="checkbox"/> Gums <input type="checkbox"/> Intra-articular <input type="checkbox"/> Intracranial <input type="checkbox"/> Intramuscular (with compartment syndrome) <input type="checkbox"/> Intraocular <input type="checkbox"/> Intraspinal <input type="checkbox"/> Nose <input type="checkbox"/> Pericardial <input type="checkbox"/> Other _____
Headache <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	Hazy / Blurred vision <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	Altered consciousness / confusion <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Other symptom(s) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: _____	

**SIGNS: Record the clinical findings observed between 00:00 and 24:00 on the day of assessment**

Were any signs reported on this date? <input type="radio"/> Yes <input type="radio"/> No	If Yes:	
Hypothermia <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Cold / clammy peripheries <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Dehydration <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Dehydration Status	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe
Oedema <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Reduced urine output <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Respiratory distress <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	Fast breathing (tachypnoea) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Rapid heart rate (tachycardia) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Peripheral cyanosis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Ascites <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Palpable liver/Hepatomegaly <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown

Palpable spleen/splenomegaly <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Tender abdomen <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
Anaemia <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Cognitive impairment <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Agitation <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Subconjunctival haemorrhage <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
Other sign(s) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: _____	

**TREATMENTS & INTERVENTIONS: Record all interventions given between 00:00 to 24:00 on day of assessment.**

Enter Treatments & Interventions data for this date? <input type="radio"/> Yes <input type="radio"/> No	If Yes, complete the form:	
Any fluids prescribed <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
Oral rehydration <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Oral rehydration volume (mL/24 hours) _____	
Intravenous (parenteral) fluids <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Intravenous fluid type	<input type="checkbox"/> 0.9% Sodium Chloride (Normal Saline) <input type="checkbox"/> Albumin <input type="checkbox"/> Hartmann's Solution / Ringer's Lactate <input type="checkbox"/> Other _____
Blood / blood products transfusion <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Select all blood products that were administered.	<input type="checkbox"/> Platelets <input type="checkbox"/> Cryoprecipitate <input type="checkbox"/> Whole blood <input type="checkbox"/> Frozen fresh plasma <input type="checkbox"/> Fibrinogen concentrate <input type="checkbox"/> Packed RBC (red cell concentrate)
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	Antiviral <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Corticosteroid <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Immunomodulators <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	

**RESPIRATORY SUPPORT: Record all respiratory interventions given between 00:00 to 24:00 on day of assessment.**

Supplemental oxygen <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes, complete the form:	
Oxygen saturation with supplemental oxygen (%) _____	Nasal prongs <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	

Face mask	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	High flow nasal oxygen	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Non-invasive ventilation	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Type of non-invasive ventilation	<input type="radio"/> CPAP <input type="radio"/> BIPAP <input type="radio"/> Unknown <input type="radio"/> Other
Invasive ventilation	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
Extracorporeal life support therapy (ECLS) / Extracorporeal membrane oxygenation (ECMO)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Type of ECLS / ECMO	<input type="radio"/> Veno-venous (VV) <input type="radio"/> Veno-arterial (VA) <input type="radio"/> Unknown
Prone positioning	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: When was the prone positioning?	<input type="radio"/> During invasive ventilation <input type="radio"/> Whilst self-ventilating <input type="radio"/> Unknown
Was PaO <sub>2</sub> measured today?	<input type="radio"/> Arterial <input type="radio"/> Capillary <input type="radio"/> Venous <input type="radio"/> Unknown <input type="radio"/> Not done	If Arterial, Capillary, Venous:	
PaO <sub>2</sub>	_____ <input type="radio"/> kPa <input type="radio"/> mmHg	FiO <sub>2</sub> at time of PaO <sub>2</sub>	_____ <input type="radio"/> Fraction, 0.21-1.0 <input type="radio"/> %, 21-100

**ADVANCED CARE INTERVENTIONS: Record all advanced care interventions given between 00:00 to 24:00 on day of assessment.**

Were advanced care (including acute organ support and critical care) therapeutic interventions administered on this date?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes, complete the form:	
ICU / ITU / HDU / Intermediate Care Unit admission	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Neuromuscular blocking agents	<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		
Renal replacement therapy (RRT) or dialysis / hemofiltration	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Type of renal replacement therapy (RRT) or dialysis / hemofiltration	<input type="radio"/> Intermittent <input type="radio"/> Continuous <input type="radio"/> Unknown
Any vasopressor / inotropic support	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes:	
Reason for vasopressor / inotrope use	<input type="checkbox"/> Shock <input type="checkbox"/> Persistent hypotension <input type="checkbox"/> Other <input type="checkbox"/> Unknown	Vasopressor / Inotropic support type	<input type="radio"/> Dopamine < 5ug/kg/min OR dobutamine OR milrinone OR levosimendan <input type="radio"/> Dopamine 5-15ug/kg/min OR epinephrine(adrenaline) / norepinephrine(noradrenaline) / norepinephrine(noradrenaline) <=0.1ug/kg/min OR vasopressin OR phenylephrine <input type="radio"/> Dopamine >15ug/kg/min OR epinephrine(adrenaline) / norepinephrine(noradrenaline) >0.1ug/kg/min

Other advanced care intervention(s) or procedure(s) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Specify other advanced care intervention(s) or procedure(s) _____
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**LABORATORY RESULTS: Record the value furthest from normal range between 00:00 to 24:00 on day of assessment.**

Enter Laboratory Results data for this date? <input type="radio"/> Yes <input type="radio"/> No	If Yes, complete the form:
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Haemoglobin _____ <small>○g/dL ○g/L</small>	White blood cell (WBC) count (10 <sup>9</sup> /L) _____	Neutrophils _____ <small>○10<sup>9</sup>/L ○%</small>
Lymphocytes _____ <small>○10<sup>9</sup>/L ○%</small>	Eosinophils _____ <small>○10<sup>9</sup>/L ○%</small>	Haematocrit _____ <small>○% ○L/L</small>
Platelets _____ <small>○10<sup>9</sup>/L ○10<sup>3</sup>/μL</small>	Left shift present <input type="radio"/> No <input type="radio"/> Yes	Circulating immunoblasts (%) _____
Ery. mean corpuscular volume (MCV) (fL) _____	Ery. mean corpuscular haemoglobin concentration _____ <small>○g/L ○g/dL</small>	
Ery. mean corpuscular haemoglobin (MCH) (pg) _____	Prothrombin Time (PT) (s) _____	
Activated Partial Thromboplastin Time (APTT) (s) _____	Activated Partial Thromboplastin Time Ratio (APTR) _____	
International Normalized Ratio (INR) _____	D-Dimer _____ <small>○mg/L ○μg/L</small>	
Total bilirubin _____ <small>○μmol/L ○mg/dL</small>	Alanine aminotransferase (ALT) / SGPT (U/L) _____	
Aspartate aminotransferase (AST) / SGOT (U/L) _____	Alkaline phosphatase (ALP) / (IU/L) _____	
Gamma Glutamyl Transferase (GGT) (U/L) _____	C-reactive protein (CRP) _____ <small>○mg/L ○mg/dL</small>	
Ferritin (μg/L or ng/mL) _____	Lactate dehydrogenase (LDH) (U/L) _____	
Random blood glucose _____ <small>○mmol/L ○mg/dL ○g/L</small>	HDL cholesterol _____ <small>○mmol/L ○mg/dL</small>	LDL cholesterol _____ <small>○mmol/L ○mg/dL</small>
Triglycerides _____ <small>○mmol/L ○mg/dL</small>	Blood Urea Nitrogen _____ <small>○mmol/L ○mg/dL</small>	Creatinine _____ <small>○μmol/L ○mg/dL</small>
Cystatin C (mg/L) _____	Sodium (mmol/L or mEq/L) _____	Potassium (mmol/L or mEq/L) _____
Blood Lactate _____ <small>○mmol/L ○mg/dL</small>	Blood gas specimen type <input type="radio"/> Arterial <input type="radio"/> Capillary <input type="radio"/> Venous <input type="radio"/> Unknown	pH _____
Bicarbonate (HCO <sub>3</sub> <sup>-</sup> ) (mmol/L or mEq/L) _____	Base Excess (mmol/L) _____	Interleukin-6 (IL-6) (pg/mL or ng/L) _____

Interleukin-1 (IL-1)(pg/mL or ng/L) _____	Albumin _____ Og/L Og/dL
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**IMAGING**

Enter Imaging data for this date?	<input type="radio"/> Yes <input type="radio"/> No	If Yes, complete the form:	
Chest X-ray performed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Chest X-ray date [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ]	
Chest X-ray findings associated with this illness.	<input type="radio"/> Normal or no acute change <input type="radio"/> Abnormal or acute change <input type="radio"/> Unknown		
New infiltrates present on X-ray	<input type="radio"/> Yes, bilateral <input type="radio"/> Yes, unilateral <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Infiltrates on X-ray consistent with	<input type="checkbox"/> Viral pneumonitis <input type="checkbox"/> Bacterial pneumonia <input type="checkbox"/> Pulmonary oedema <input type="checkbox"/> Unknown
Pleural effusion on X-ray	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes:	
Pleural effusion on X-ray details	<input type="radio"/> Unilateral <input type="radio"/> Bilateral	Side(s) where pleural effusion identified	<input type="checkbox"/> Right <input type="checkbox"/> Left
CT chest performed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
CT chest findings associated with this illness	<input type="radio"/> Normal or no acute change <input type="radio"/> Abnormal or acute change <input type="radio"/> Unknown		
New infiltrates present on CT	<input type="radio"/> Yes, bilateral <input type="radio"/> Yes, unilateral <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Infiltrates on CT chest consistent with	<input type="checkbox"/> Viral pneumonitis <input type="checkbox"/> Bacterial pneumonia <input type="checkbox"/> Pulmonary oedema <input type="checkbox"/> Unknown
Pleural effusion on CT chest	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Pleural effusion on CT chest details	<input type="radio"/> Unilateral <input type="radio"/> Bilateral
Ultrasound performed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes:	
Ultrasound date	[ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ] [ _ ]	Ultrasound region	<input type="radio"/> Chest only <input type="radio"/> Abdomen only <input type="radio"/> Chest and abdomen <input type="radio"/> Cranial <input type="radio"/> Joints <input type="radio"/> Unknown
Ultrasound findings associated with this illness	<input type="radio"/> Normal or no acute change <input type="radio"/> Abnormal or acute change <input type="radio"/> Unknown		
Ascites	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Ascites grading	<input type="radio"/> Small <input type="radio"/> Moderate <input type="radio"/> Severe

Consolidation	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
Pleural effusion	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes:	
Pleural effusion right size (cm)	_____	Pleural effusion left size (cm)	_____
Pericardial effusion	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Pericardial effusion size (cm) _____	
Liver size (cm)	_____	Gallbladder wall (mm)	_____
Electrocardiogram (ECG)	<input type="radio"/> Yes-normal <input type="radio"/> Yes-abnormal <input type="radio"/> No <input type="radio"/> Unknown		
If Yes-abnormal: ECG summary	_____	If Yes: ECG date	[_D_] [_D_] / [_M_] [_M_] / [_Y_] [_Y_] [_Y_] ]

### RESEARCH SAMPLES

How many research samples were taken today?	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4		
If 1, 2, 3, 4: please record the KIT number sample 1	_____	If 2, 3, 4: please record the KIT number sample 2	_____
If 3, 4: please record the KIT number sample 3	_____	If 4: please record the KIT number sample 4	_____

## PATHOGEN TESTING

PATHOGEN TESTING: Results of all types of sample and pathogen testing (ONE FORM PER PATHOGEN)					
Collection date	[ DD / MM / 20YY ]	[ DD / MM / 20YY ]	[ DD / MM / 20YY ]	[ DD / MM / 20YY ]	[ DD / MM / 20YY ]
Biospecimen type	<input type="radio"/> Whole blood <input type="radio"/> Serum <input type="radio"/> Nasopharyngeal / respiratory swab <input type="radio"/> Urine <input type="radio"/> Faeces/rectal swab <input type="radio"/> Semen <input type="radio"/> Saliva <input type="radio"/> Other	<input type="radio"/> Whole blood <input type="radio"/> Serum <input type="radio"/> Nasopharyngeal / respiratory swab <input type="radio"/> Urine <input type="radio"/> Faeces/rectal swab <input type="radio"/> Semen <input type="radio"/> Saliva <input type="radio"/> Other	<input type="radio"/> Whole blood <input type="radio"/> Serum <input type="radio"/> Nasopharyngeal / respiratory swab <input type="radio"/> Urine <input type="radio"/> Faeces/rectal swab <input type="radio"/> Semen <input type="radio"/> Saliva <input type="radio"/> Other	<input type="radio"/> Whole blood <input type="radio"/> Serum <input type="radio"/> Nasopharyngeal / respiratory swab <input type="radio"/> Urine <input type="radio"/> Faeces/rectal swab <input type="radio"/> Semen <input type="radio"/> Saliva <input type="radio"/> Other	<input type="radio"/> Whole blood <input type="radio"/> Serum <input type="radio"/> Nasopharyngeal / respiratory swab <input type="radio"/> Urine <input type="radio"/> Faeces/rectal swab <input type="radio"/> Semen <input type="radio"/> Saliva <input type="radio"/> Other
Pathogen tested / detected	<input type="radio"/> Hantavirus <input type="radio"/> Leptospira spp. <input type="radio"/> Dengue virus <input type="radio"/> Influenza A <input type="radio"/> SARS-CoV-2 <input type="radio"/> Other	<input type="radio"/> Hantavirus <input type="radio"/> Leptospira spp. <input type="radio"/> Dengue virus <input type="radio"/> Influenza A <input type="radio"/> SARS-CoV-2 <input type="radio"/> Other	<input type="radio"/> Hantavirus <input type="radio"/> Leptospira spp. <input type="radio"/> Dengue virus <input type="radio"/> Influenza A <input type="radio"/> SARS-CoV-2 <input type="radio"/> Other	<input type="radio"/> Hantavirus <input type="radio"/> Leptospira spp. <input type="radio"/> Dengue virus <input type="radio"/> Influenza A <input type="radio"/> SARS-CoV-2 <input type="radio"/> Other	<input type="radio"/> Hantavirus <input type="radio"/> Leptospira spp. <input type="radio"/> Dengue virus <input type="radio"/> Influenza A <input type="radio"/> SARS-CoV-2 <input type="radio"/> Other
Lab test method	<input type="radio"/> PCR <input type="radio"/> Culture <input type="radio"/> RDT <input type="radio"/> Serology (ELISA) <input type="radio"/> Other NAAT <input type="radio"/> Unknown	<input type="radio"/> PCR <input type="radio"/> Culture <input type="radio"/> RDT <input type="radio"/> Serology (ELISA) <input type="radio"/> Other NAAT <input type="radio"/> Unknown	<input type="radio"/> PCR <input type="radio"/> Culture <input type="radio"/> RDT <input type="radio"/> Serology (ELISA) <input type="radio"/> Other NAAT <input type="radio"/> Unknown	<input type="radio"/> PCR <input type="radio"/> Culture <input type="radio"/> RDT <input type="radio"/> Serology (ELISA) <input type="radio"/> Other NAAT <input type="radio"/> Unknown	<input type="radio"/> PCR <input type="radio"/> Culture <input type="radio"/> RDT <input type="radio"/> Serology (ELISA) <input type="radio"/> Other NAAT <input type="radio"/> Unknown
Lab marker	<input type="radio"/> NS1 Ag <input type="radio"/> IgG <input type="radio"/> IgM <input type="radio"/> IgA <input type="radio"/> Viral RNA <input type="radio"/> Not applicable <input type="radio"/> Other <input type="radio"/> Unknown	<input type="radio"/> NS1 Ag <input type="radio"/> IgG <input type="radio"/> IgM <input type="radio"/> IgA <input type="radio"/> Viral RNA <input type="radio"/> Not applicable <input type="radio"/> Other <input type="radio"/> Unknown	<input type="radio"/> NS1 Ag <input type="radio"/> IgG <input type="radio"/> IgM <input type="radio"/> IgA <input type="radio"/> Viral RNA <input type="radio"/> Not applicable <input type="radio"/> Other <input type="radio"/> Unknown	<input type="radio"/> NS1 Ag <input type="radio"/> IgG <input type="radio"/> IgM <input type="radio"/> IgA <input type="radio"/> Viral RNA <input type="radio"/> Not applicable <input type="radio"/> Other <input type="radio"/> Unknown	<input type="radio"/> NS1 Ag <input type="radio"/> IgG <input type="radio"/> IgM <input type="radio"/> IgA <input type="radio"/> Viral RNA <input type="radio"/> Not applicable <input type="radio"/> Other <input type="radio"/> Unknown
Pathogen test result	<input type="radio"/> Detected <input type="radio"/> Not detected <input type="radio"/> Equivocal <input type="radio"/> Unknown	<input type="radio"/> Detected <input type="radio"/> Not detected <input type="radio"/> Equivocal <input type="radio"/> Unknown	<input type="radio"/> Detected <input type="radio"/> Not detected <input type="radio"/> Equivocal <input type="radio"/> Unknown	<input type="radio"/> Detected <input type="radio"/> Not detected <input type="radio"/> Equivocal <input type="radio"/> Unknown	<input type="radio"/> Detected <input type="radio"/> Not detected <input type="radio"/> Equivocal <input type="radio"/> Unknown
Cycle threshold (CT) value					
Viral load (copies/mL)					
Genomic repository	<input type="radio"/> EMBL - European Bioinformatics Institute (EBI) <input type="radio"/> Other	<input type="radio"/> EMBL - European Bioinformatics Institute (EBI) <input type="radio"/> Other	<input type="radio"/> EMBL - European Bioinformatics Institute (EBI) <input type="radio"/> Other	<input type="radio"/> EMBL - European Bioinformatics Institute (EBI) <input type="radio"/> Other	<input type="radio"/> EMBL - European Bioinformatics Institute (EBI) <input type="radio"/> Other
Repository sequence identifier					

## MEDICATION

**MEDICATION: Complete one form for each medication prescribed from the day of presentation (the start of data capture) to the day of discharge.**

Type of agent	<input type="radio"/> Antiviral <input type="radio"/> Corticosteroid <input type="radio"/> Analgesic <input type="radio"/> Antibiotic <input type="radio"/> Anticoagulant <input type="radio"/> Immunosuppressive drugs (non-steroid) <input type="radio"/> Inotropes / vasopressor <input type="radio"/> Intravenous immunoglobulin <input type="radio"/> Other	<input type="radio"/> Antiviral <input type="radio"/> Corticosteroid <input type="radio"/> Analgesic <input type="radio"/> Antibiotic <input type="radio"/> Anticoagulant <input type="radio"/> Immunosuppressive drugs (non-steroid) <input type="radio"/> Inotropes / vasopressor <input type="radio"/> Intravenous immunoglobulin <input type="radio"/> Other	<input type="radio"/> Antiviral <input type="radio"/> Corticosteroid <input type="radio"/> Analgesic <input type="radio"/> Antibiotic <input type="radio"/> Anticoagulant <input type="radio"/> Immunosuppressive drugs (non-steroid) <input type="radio"/> Inotropes / vasopressor <input type="radio"/> Intravenous immunoglobulin <input type="radio"/> Other	<input type="radio"/> Antiviral <input type="radio"/> Corticosteroid <input type="radio"/> Analgesic <input type="radio"/> Antibiotic <input type="radio"/> Anticoagulant <input type="radio"/> Immunosuppressive drugs (non-steroid) <input type="radio"/> Inotropes / vasopressor <input type="radio"/> Intravenous immunoglobulin <input type="radio"/> Other	<input type="radio"/> Antiviral <input type="radio"/> Corticosteroid <input type="radio"/> Analgesic <input type="radio"/> Antibiotic <input type="radio"/> Anticoagulant <input type="radio"/> Immunosuppressive drugs (non-steroid) <input type="radio"/> Inotropes / vasopressor <input type="radio"/> Intravenous immunoglobulin <input type="radio"/> Other
Is this medication treating the disease?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Medication Name					
Date medication started / first dose	[ DD / MM / 20YY ]	[ DD / MM / 20YY ]	[ DD / MM / 20YY ]	[ DD / MM / 20YY ]	[ DD / MM / 20YY ]
Date medication stopped / last dose	[ DD / MM / 20YY ]	[ DD / MM / 20YY ]	[ DD / MM / 20YY ]	[ DD / MM / 20YY ]	[ DD / MM / 20YY ]
Total number of days treatment given					
Medication route	<input type="radio"/> Oral <input type="radio"/> Subcutaneous <input type="radio"/> Inhaled <input type="radio"/> IV <input type="radio"/> Topical <input type="radio"/> Unknown <input type="radio"/> Other	<input type="radio"/> Oral <input type="radio"/> Subcutaneous <input type="radio"/> Inhaled <input type="radio"/> IV <input type="radio"/> Topical <input type="radio"/> Unknown <input type="radio"/> Other	<input type="radio"/> Oral <input type="radio"/> Subcutaneous <input type="radio"/> Inhaled <input type="radio"/> IV <input type="radio"/> Topical <input type="radio"/> Unknown <input type="radio"/> Other	<input type="radio"/> Oral <input type="radio"/> Subcutaneous <input type="radio"/> Inhaled <input type="radio"/> IV <input type="radio"/> Topical <input type="radio"/> Unknown <input type="radio"/> Other	<input type="radio"/> Oral <input type="radio"/> Subcutaneous <input type="radio"/> Inhaled <input type="radio"/> IV <input type="radio"/> Topical <input type="radio"/> Unknown <input type="radio"/> Other
Frequency					
Dose	↓mg ↓g ↓μg ↓IU ↓mg/kg ↓mg/day ↓mL ↓mL/h ↓% ↓tablets ↓Other	↓mg ↓g ↓μg ↓IU ↓mg/kg ↓mg/day ↓mL ↓mL/h ↓% ↓tablets ↓Other	↓mg ↓g ↓μg ↓IU ↓mg/kg ↓mg/day ↓mL ↓mL/h ↓% ↓tablets ↓Other	↓mg ↓g ↓μg ↓IU ↓mg/kg ↓mg/day ↓mL ↓mL/h ↓% ↓tablets ↓Other	↓mg ↓g ↓μg ↓IU ↓mg/kg ↓mg/day ↓mL ↓mL/h ↓% ↓tablets ↓Other
Was this an off-label or compassionate use of the medication?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown

## RESEARCH SAMPLES

### RESEARCH SAMPLES

If yes, please record  
the KIT number: \_\_\_\_\_

Date sample  
obtained: \_\_\_\_\_

[\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_Y\_][\_Y\_][\_Y\_]

## OUTCOME

<b>COMPLICATIONS: Experienced at any time from day of presentation to day of discharge / outcome.</b>			
Stroke / cerebrovascular accident <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Encephalopathy <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	
Encephalitis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Meningitis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Cardiac ischaemia <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Endocarditis <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	
Cardiac arrhythmia <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Cardiac arrest <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Myocarditis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Pericarditis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
Pneumonia / pneumonitis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Etiology of pneumonia	<input type="radio"/> Viral <input type="radio"/> Bacterial <input type="radio"/> Fungal	
Pneumothorax <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Pleural effusion <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Cryptogenic organising pneumonia (COP) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Bronchiolitis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Acute Respiratory Distress Syndrome (ARDS) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Ascites <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Pancreatitis <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	Liver dysfunction <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Thromboembolism <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes:		
Pulmonary embolism (PE) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Deep vein thrombosis (DVT) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
Severe bleeding (requiring intervention) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Severe bleeding site(s)	<input type="checkbox"/> Skin <input type="checkbox"/> Petechiae <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(s) <input type="checkbox"/> Unknown	
Anaemia <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	Acute renal injury / acute renal failure <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Urinary tract infection <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Rhabdomyolysis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Myositis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	

Cellulitis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Skin abscess <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Skin tissue loss or eschar <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Bacteraemia <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Hyperglycemia <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Hypoglycaemia <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		
Re-shock episodes <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Number of re-shock episodes	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4+ <input type="radio"/> Unknown
Sepsis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Hypothermia <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Other complication(s) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes:	_____

### SEVERITY ASSESSMENT

Hospitalized during observation period? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes:	
ICU admission <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	High-flow nasal cannula (HFNC) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Non-invasive ventilation <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Mechanical ventilation <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Vasopressor/inotropic support <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Renal replacement therapy (RRT) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
ECMO support <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		

### DIAGNOSIS

Primary diagnosis <input type="radio"/> Andes virus infection (hantavirus) <input type="radio"/> Other _____	Type of diagnosis <input type="checkbox"/> Clinical diagnosis <input type="checkbox"/> Lab-confirmed <input type="checkbox"/> Radiologically confirmed (e.g., chest X-ray, CT) <input type="checkbox"/> Unknown <input type="checkbox"/> Other	Secondary diagnosis <input type="radio"/> Other _____
Type of diagnosis <input type="checkbox"/> Clinical diagnosis <input type="checkbox"/> Lab-confirmed <input type="checkbox"/> Radiologically confirmed (e.g., chest X-ray, CT) <input type="checkbox"/> Unknown <input type="checkbox"/> Other		

<b>OUTCOME</b>	
Outcome date	[ _D_ ][ _D_ ][ / ][ _M_ ][ _M_ ][ / ][ _Y_ ][ _Y_ ][ _Y_ ][ _Y_ ]
Outcome	<input type="radio"/> Alive, never hospitalised <input type="radio"/> Discharged alive <input type="radio"/> Death <input type="radio"/> Discharged against medical advice <input type="radio"/> Palliative care <input type="radio"/> Still hospitalised <input type="radio"/> Transfer to other facility <input type="radio"/> Other <hr style="width: 20%; margin-left: 0;"/>
Ability to self-care at discharge versus before illness	<input type="radio"/> Same as before illness <input type="radio"/> Worse <input type="radio"/> Better <input type="radio"/> Unknown
If discharged alive or still hospitalised: Ongoing health care needs relating to this admission for pathogen of interest	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
If Still hospitalised or transfer to other facility: Medically fit for discharge (pathogen resolved) but remains in hospital for other reason (e.g. awaiting alternate care, resident in long term health care or mental health facility)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
If discharged alive: Oxygen therapy post-discharge treatment	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
If discharged alive or still hospitalised: Ongoing health care needs NOT related to pathogen episode	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
If transfer to other facility: is the transfer facility a study site?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
If Yes: What is the Participant Identification Number at the new facility?	<hr style="width: 100%;"/>

## WITHDRAWAL

WITHDRAWAL	
Date of withdrawal [ _D_ ][ _D_ ][ _M_ ][ _M_ ][ _Y_ ][ _Y_ ][ _Y_ ][ _Y_ ]	Reason for withdrawal _____
Did the participant withdraw from active participation in the study? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Did the participant withdraw consent to use data collected up until the point of withdrawal? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Did the participant withdraw consent to use samples collected up until the point of withdrawal? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	