

ISARIC HANTAVIRUS CRF

DESIGN OF THIS CASE REPORT FORM (CRF)

This CRF is set up in modules to be used for recording data on Hantavirus. 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
- 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 [] [] / [] [] / [] [] [] []
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

<p>Consent has been obtained for the collection of samples including DNA:</p> <p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/K </p>	<p>Consent options (select all to which the patient agreed):</p> <p> <input type="checkbox"/> Data and samples may be used for other unrelated ethically approved research <input type="checkbox"/> Data and samples can be used to manufacture tests, treatments, or other products, including commercial products <input type="checkbox"/> De-identified data and results of analyses, can be shared with other scientists, including those in other countries <input type="checkbox"/> Participant may be contacted by the investigators to be invited to participate in future work, including research studies </p>
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EXPOSURE HISTORY IN PREVIOUS 49 DAYS

Did the patient travel outside of their home region in the past 14 days?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
History of contact with suspected or confirmed human case of same pathogen?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Community contact	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Healthcare worker exposure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Sexual transmission	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Family / household contacts	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Contact setting	<input type="radio"/> Household <input type="radio"/> Occupational <input type="radio"/> Healthcare facility <input type="radio"/> Unknown <input type="radio"/> Other _____
Date of contact with suspected or confirmed case	[_] [_] [_] [_] [_] / [_] [_] [_] [_] [_] [_] [_] [_] [_]

Exposure to confirmed or suspected case on board

Shared cabin with confirmed or suspected case	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Shared bathroom facilities with confirmed or suspected case	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Shared meals with confirmed or suspected case	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Participated in social activities with confirmed or suspected case	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Participated in shared shore/off-boat excursions with confirmed or suspected case	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
Worked or spent prolonged time in the same enclosed area as confirmed or suspected case	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Cabin number (if known)	_____		
Deck/floor of cabin	_____				
Any unwell household members in the two weeks prior to the admission of case?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Which system(s) are affected? (tick all that apply)	<input type="checkbox"/> Respiratory <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Central Nervous system <input type="checkbox"/> Peripheral Nervous system <input type="checkbox"/> Mucocutaneous <input type="checkbox"/> Ocular <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____		
Have household members had any contact with a confirmed case of the same infection?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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
Any contact with animals, animal homes, meats or other animal products in the last 49 days? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes: Date of contact with suspected or confirmed animal source _____
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 <input type="checkbox"/> Squirrels	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	
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 _____	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
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	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
Chronic haematologic disease	<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
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
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	_____	
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: _____

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	If Yes: Persistent vomiting? (>=2/day)	<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	Pain during urination (dysuria)	<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	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	Paralysis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		

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: If yes: specify test result from mother's infection of interest	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown
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INFANT: LESS THAN 12 MONTHS OLD

Birth weight	_____ <input type="radio"/> g <input type="radio"/> lb	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 <ul style="list-style-type: none"> <input type="radio"/> Outpatient <input type="radio"/> Admitted to normal ward for isolation only <input type="radio"/> Admitted to normal ward for clinical care <input type="radio"/> High dependency <input type="radio"/> Intensive care admission

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? <ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No 		If Yes, complete the form:	
Highest temperature _____ <input type="radio"/> °C <input type="radio"/> °F	Heart Rate (bpm) _____	Respiratory Rate (breaths/min) _____	
Systolic BP (mmHg) _____	Diastolic BP (mmHg) _____	Mean arterial blood pressure (mmHg) _____	
Oxygen saturation at room air (no oxygen support) (%) _____		How was oxygen saturation at room air measured? <ul style="list-style-type: none"> <input type="radio"/> Pulse Oximetry <input type="radio"/> Arterial blood gas measurement <input type="radio"/> Other <input type="radio"/> Unknown 	
Supplemental oxygen? <ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown 		If Yes:	
Type of supplemental oxygen? <ul style="list-style-type: none"> <input type="radio"/> Nasal Prongs <input type="radio"/> Face mask <input type="radio"/> High flow nasal oxygen <input type="radio"/> Non-invasive ventilation <input type="radio"/> Invasive ventilation <input type="radio"/> ECMO / ECLS <input type="radio"/> Unknown 		Oxygen saturation with supplemental oxygen (%) _____	
How was oxygen saturation with supplemental oxygen measured? <ul style="list-style-type: none"> <input type="radio"/> Pulse Oximetry <input type="radio"/> Arterial blood gas measurement <input type="radio"/> Other <input type="radio"/> Unknown 		FiO2 at time of lowest SpO2 _____	<input type="radio"/> Fraction, 0.21-1.0 <input type="radio"/> %, 21-100 <input type="radio"/> Highest L/min
Capillary refill time >2 seconds <ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown 	ACVPU <ul style="list-style-type: none"> <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.			
Enter patient reported symptoms data for this date? <ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No 		If Yes, complete the form:	
Fever <ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown 	Chills or rigors <ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown 	Fatigue / malaise / lethargy <ul style="list-style-type: none"> <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	Skin rash <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	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	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

Enter clinical signs data for 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

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:	
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"/> Venovenous (VV) <input type="radio"/> Venovenous (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
PaO2 sample type	<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:	
PaO2	_____	FiO2 at time of PaO2	_____
	<input type="radio"/> kPa <input type="radio"/> mmHg		<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="checkbox"/> Dopamine (<5ug/kg/min) <input type="checkbox"/> Dopamine (5-15ug/kg/min) <input type="checkbox"/> Dopamine (>15ug/kg/min) <input type="checkbox"/> Norepinephrine (noradrenaline) < 0.1ug/kg/min <input type="checkbox"/> Norepinephrine (noradrenaline) > 0.1ug/kg/min <input type="checkbox"/> Epinephrine (adrenaline) <input type="checkbox"/> Dobutamine <input type="checkbox"/> Milrinone <input type="checkbox"/> Levosimendan <input type="checkbox"/> Vasopressin <input type="checkbox"/> Phenylephrine <input type="checkbox"/> Terlipressin <input type="checkbox"/> Angiotensin-II
Other advanced care intervention(s) or procedure(s)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		

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:	
Haemoglobin _____ ○g/dL ○g/L	White blood cell (WBC) count (10 ⁹ /L) _____	Neutrophils _____ ○10 ⁹ /L ○%	
Lymphocytes _____ ○10 ⁹ /L ○%	Eosinophils _____ ○10 ⁹ /L ○%	Haematocrit _____ ○% ○L/L	
Platelets _____ ○10 ⁹ /L ○10 ³ /μL		Ery. mean corpuscular volume (MCV) (fL) _____	
Ery. mean corpuscular haemoglobin concentration _____ ○g/L ○g/dL		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) _____	
Alanine aminotransferase (ALT) / SGPT (U/L) _____		Aspartate aminotransferase (AST) / SGOT (U/L) _____	
Alkaline phosphatase (ALP) / (IU/L) _____		Gamma Glutamyl Transferase (GGT) (U/L) _____	
D-Dimer _____ ○mg/L ○μg/L	C-reactive protein (CRP) _____ ○mg/L ○mg/dL	Ferritin (μg/L or ng/mL) _____	
Random blood glucose _____ ○mmol/L ○mg/dL ○g/L	Blood Urea Nitrogen _____ ○mmol/L ○mg/dL	Creatinine _____ ○μmol/L ○mg/dL	
Sodium (mmol/L or mEq/L) _____		Potassium (mmol/L or mEq/L) _____	

Lactate dehydrogenase (LDH) (U/L) _____	Blood gas specimen type <input type="radio"/> Arterial <input type="radio"/> Capillary <input type="radio"/> Venous <input type="radio"/> Unknown	
pH _____	Bicarbonate (HCO ₃ ⁻) (mmol/L or mEq/L) _____	Base Excess (mmol/L) _____
Interleukin-6 (IL-6) (pg/mL or ng/L) _____		

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		
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	[_] [_] [_] [_] [_] [_] [_] [_] [_] [_]

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	_____

MEDICATION

Any medications given?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes, complete the form:
Please enter each medication on a Medication form which can be found on the Record Home Page.		

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"/> Plasma <input type="radio"/> Nasopharyngeal / respiratory swab <input type="radio"/> Urine <input type="radio"/> Other	<input type="radio"/> Whole blood <input type="radio"/> Serum <input type="radio"/> Plasma <input type="radio"/> Nasopharyngeal / respiratory swab <input type="radio"/> Urine <input type="radio"/> Other	<input type="radio"/> Whole blood <input type="radio"/> Serum <input type="radio"/> Plasma <input type="radio"/> Nasopharyngeal / respiratory swab <input type="radio"/> Urine <input type="radio"/> Other	<input type="radio"/> Whole blood <input type="radio"/> Serum <input type="radio"/> Plasma <input type="radio"/> Nasopharyngeal / respiratory swab <input type="radio"/> Urine <input type="radio"/> Other	<input type="radio"/> Whole blood <input type="radio"/> Serum <input type="radio"/> Plasma <input type="radio"/> Nasopharyngeal / respiratory swab <input type="radio"/> Urine <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 (NAAT) <input type="radio"/> Culture <input type="radio"/> RDT <input type="radio"/> ELISA <input type="radio"/> Other NAAT <input type="radio"/> Unknown	<input type="radio"/> PCR (NAAT) <input type="radio"/> Culture <input type="radio"/> RDT <input type="radio"/> ELISA <input type="radio"/> Other NAAT <input type="radio"/> Unknown	<input type="radio"/> PCR (NAAT) <input type="radio"/> Culture <input type="radio"/> RDT <input type="radio"/> ELISA <input type="radio"/> Other NAAT <input type="radio"/> Unknown	<input type="radio"/> PCR (NAAT) <input type="radio"/> Culture <input type="radio"/> RDT <input type="radio"/> ELISA <input type="radio"/> Other NAAT <input type="radio"/> Unknown	<input type="radio"/> PCR (NAAT) <input type="radio"/> Culture <input type="radio"/> RDT <input type="radio"/> ELISA <input type="radio"/> Other NAAT <input type="radio"/> Unknown
Lab marker	<input type="checkbox"/> NS1 Ag <input type="checkbox"/> IgG <input type="checkbox"/> IgM <input type="checkbox"/> IgA <input type="checkbox"/> Viral load / serotype (PCR/NAAT) <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	<input type="checkbox"/> NS1 Ag <input type="checkbox"/> IgG <input type="checkbox"/> IgM <input type="checkbox"/> IgA <input type="checkbox"/> Viral load / serotype (PCR/NAAT) <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	<input type="checkbox"/> NS1 Ag <input type="checkbox"/> IgG <input type="checkbox"/> IgM <input type="checkbox"/> IgA <input type="checkbox"/> Viral load / serotype (PCR/NAAT) <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	<input type="checkbox"/> NS1 Ag <input type="checkbox"/> IgG <input type="checkbox"/> IgM <input type="checkbox"/> IgA <input type="checkbox"/> Viral load / serotype (PCR/NAAT) <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	<input type="checkbox"/> NS1 Ag <input type="checkbox"/> IgG <input type="checkbox"/> IgM <input type="checkbox"/> IgA <input type="checkbox"/> Viral load / serotype (PCR/NAAT) <input type="checkbox"/> Not applicable <input type="checkbox"/> 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_] [_Y_]

OUTCOME

COMPLICATIONS: Experienced at any time from day of presentation to day of discharge / outcome.			
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:	_____

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		

OUTCOME

Outcome date	[_] [_] [_] [_] [_] [_] [_] [_] [_] [_]
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 _____	If Discharged alive, Still hospitalised, Transfer to other facility:
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: 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 relating to this admission for pathogen of interest

Yes
 No
 Unknown

If discharged alive or still hospitalised:
Ongoing health care needs NOT related to pathogen episode

Yes
 No
 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)

Yes
 No
 Unknown

If transfer to other facility: is the transfer facility a study site?

Yes
 No
 Unknown

If Yes: What is the Participant Identification Number at the new facility?

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	