NAVIS HANTAVIRUS CRF

DESIGN OF THIS CASE REPORT FORM

This CRF is set up in modules to be used for recording data on NAVIS hantavirus Database. A template for completion instructions is below. This should be tailored to the objectives of your data collection.

Figure 1. REDCap event-instrument matrix

Data Collection Instrument	Enrolment	Tier 1						Tier 2						Tier 3						Summary	Discharge / Outcome
		W1	W2	W3	W4	W5	W6	W1	W2	W3	W4	W5	W6	W1	W2	W3	W4	W5	W6		
Patient Tier Status	ⓘ	ⓘ	ⓘ	ⓘ	ⓘ	ⓘ	ⓘ	ⓘ	ⓘ	ⓘ	ⓘ	ⓘ	ⓘ	ⓘ	ⓘ	ⓘ	ⓘ	ⓘ	ⓘ		
Inclusion Criteria	✓																				
Consent	✓																				
Epidemiological Assessment	✓																				
Presentation	✓																				
Daily		↻	↻	↻	↻	↻	↻	↻	↻	↻	↻	↻	↻	↻	↻	↻	↻	↻	↻		
Clinical Labs		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Clinical Labs 2								✓	✓	✓	✓			✓	✓	✓	✓				
Virology And Immunology		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Virology And Immunology 2			✓	✓	✓	✓		✓	✓	✓	✓			✓	✓	✓	✓				
Medication																				↻	
Outcome																					✓

ⓘ Information only; ✓ Complete once; ↻ Repeatable assessment/form.

General guidance

- Contact the study data team or REDCap administrator for project-specific questions.
- The CRF is designed to collect data from examinations, interviews, review of hospital notes, and/or extraction from electronic health records.
- Data may be entered prospectively or retrospectively, depending on when the participant is enrolled and when information becomes available.
- Participant Identification Numbers should follow the site coding convention used by the project (for example, a site code plus sequential participant number).
- If a participant is re-admitted to the same site, create a new record and follow the local rule for re-admission or prior PIN tracking.
- If a participant transfers between sites, follow the project rule for whether the first site closes the record, and the second site opens a new one.
- Data entry instructions: Circles indicate that only one option may be selected, while square boxes indicate that multiple options may be selected. Use “Unknown” only when the information cannot be determined from the available source data.
- The “onset date” in the Presentation form captures symptoms present at enrolment and should not be updated during follow-up. Subsequent symptom onset should be recorded in the Daily Monitoring form, which is considered the primary source for onset determination and analysis.

REDCap structure in the current export

The current XML export shows a single-arm longitudinal project with fixed weekly events and a repeated daily instrument.

Main events

Event group	Event name	Notes
Entry	Enrollment E0	Initial study entry point
Follow-up	Tier 1 Week 1 to Week 6	Daily is repeated here
Follow-up	Tier 2 Week 1 to Week 6	Daily is repeated here
Follow-up	Tier 3 Week 1 to Week 6	Daily is repeated here
Close-out	Summary	End-of-follow-up summary event
Close-out	Discharge / Outcome	Final disposition or study closure

Main instruments

Instrument	Purpose	Repeating?
tier_logic / Patient Tier Status	Guidance and tier review	No
inclusion_criteria	Eligibility verification	No
consent	Consent documentation	No
epidemiological_assessment	Exposure history and contact information	No
presentation	Baseline presentation, onset, demographics, comorbidities, vaccination, and prior medication context	No
daily	Daily monitoring, symptoms, vital signs, treatments, and supportive care	Yes, across weekly events
clinical_labs	Laboratory monitoring	No
virology_and_immunology	PCR, serology, and specimen capture	No
medication	Medication-level capture	Yes
outcome	Final clinical outcome and complications	No

Recommended use by form

- **Presentation:** Use this form for the baseline clinical picture at enrolment, including onset information, demographics, comorbidities, vaccination history, and other contextual data captured at first presentation.
- **Daily:** Use this form for the day-by-day clinical record during the weekly follow-up events. In the current XML export, it is the only instrument configured as repeated across the Tier 1, Tier 2, and Tier 3 weekly events.
- **Clinical labs:** Use these forms for laboratory values and related biomarker information.
- **Virology and immunology:** Use these forms for PCR, serology, and specimen information.
- **Medication:** Use this form for medication-level capture. If the workflow requires one record per medication, confirm whether that is being handled through site procedure or a repeating record setup.
- **Outcome:** Use this form at discharge, death, or the end of study follow-up to capture the final participant outcome and any complications.

Important operational notes

- Keep following the participant if they transfer between wards within the same site, according to the project workflow.
- Use the Patient Tier Status field as **guidance** for data entry quality control, **not as an automatic rule** that changes records by itself.
- If the project uses a REDCap screenshot for the event matrix, place it near the top of the guide so staff can see the full structure at a glance.

Participant flow summary

Enrollment E0→**Tier 1** Week 1 to Week 6→**Tier 2** Week 1 to Week 6→**Tier 3** Week 1 to Week 6→Summary →Discharge / Outcome

INCLUSION CRITERIA

Participant Identification Number (PIN) (5-digit site code and a 4-digit patient code, e.g. XXXXX-0001) _____	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

CONSENT

CONSENT			
As a research professional I certify that consent has been documented	○ Yes ○ No	Did the participant (or their representative) consent for blood samples to be used for genetic (DNA) research?	○ Yes ○ No ○ Unknown
Did the participant (or their representative) consent to participate in the Host Genetics substudy?	○ Yes ○ No ○ Unknown		

EPIDEMIOLOGICAL ASSESSMENT

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
[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Date of last contact with suspected or confirmed case
[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

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
[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

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)	○ Yes ○ No ○ Unknown	Rodent sighting or exposure on board the vessel	○ Yes ○ No ○ Unknown
Direct contact with rodents	○ Yes ○ No ○ Unknown	If Yes:	
Rodents type	☐ Rats ☐ Mice	Specify type of contact	☐ Hunting ☐ Preparing ☐ Handling ☐ Consumption (unprocessed / undercooked / raw) ☐ Trading ☐ Animal faeces or nests ☐ Sick or dead animal ☐ Unknown ☐ Other

OTHER ANIMAL EXPOSURES

Other animal exposures	○ Yes ○ No ○ Unknown		
Contact with wildlife	○ Yes ○ No ○ Unknown	If Yes: Wildlife type	☐ Bats ☐ Other _____
Any insect or arthropod bites (eg. mosquitoes, ticks)	○ Yes ○ No ○ Unknown		
Other animal contact not listed above	○ Yes ○ No ○ Unknown	If Yes: Specify animal contacts not listed above	_____

WATER / ENVIRONMENTAL EXPOSURES

Patient swam or bathed in pools, ponds, or rivers	○ Yes ○ No ○ Unknown	Exposure to flood water/stagnant water bodies or contaminated water	○ Yes ○ No ○ Unknown

PRESENTATION

ONSET & PRESENTATION

Initial clinical and PCR status at presentation	○ Exposed / asymptomatic / PCR negative ○ PCR positive / asymptomatic ○ PCR positive / Symptomatic disease ○ Unknown	Onset date of first / earliest symptom	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]
Date of first clinical consultation	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]	Most recent presentation/admission date at this facility	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]
Isolation start date	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]		
Admitted to hospital	○ Yes ○ No ○ Unknown	If Yes: Reason for hospitalisation	○ Infection of interest ○ Other

DEMOGRAPHICS

Is the date of birth known?	○ Yes ○ No				
If Yes: Date of birth	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]	If No: Age	_____ ○Years ○Months ○Days		
Sex at birth	○ Male ○ Female ○ Not specified/Unknown ○ Other _____	Gender	○ Male ○ Female ○ Non-binary ○ Unknown ○ Other _____	Length/Height	_____ ○cm ○in
Weight	_____ ○kg ○lb				
Employed as a healthcare worker	○ Yes ○ No ○ Unknown	If Yes:			
Patient facing	○ Yes ○ No ○ Unknown	Exposed to biological samples	○ Yes ○ No ○ Unknown		
Primary location of occupation	○ Home-working or unemployed ○ Indoors-office/health/education/hospitality/business/homes ○ Indoors-factory ○ Outdoors-animal contact (vet, animal farmer, abattoir worker) ○ Outdoors-agriculture/forestry/fisheries ○ Outdoors-construction/industrial/mining ○ Armed Forces ○ Student ○ Unknown ○ Other _____	Patient's city of residence	○ Same as health care facility ○ Different from health care facility ○ Unknown _____		

CO-MORBIDITIES AND RISK FACTORS: Existing prior to this current illness and is ongoing

Chronic neurological disorder	○ Yes ○ No ○ Unknown	Neurodevelopmental disorders/conditions	○ Yes ○ No ○ Unknown	Congenital heart disease	○ Yes ○ No ○ Unknown

Chronic cardiac disease (not hypertension)	○ Yes ○ No ○ Unknown		If Yes:		
Myocardial infarction	○ Yes ○ No ○ Unknown		Congestive heart failure	○ Yes ○ No ○ Unknown	
Hypertension	○ Yes ○ No ○ Unknown	Chronic pulmonary disease (not asthma)	○ Yes ○ No ○ Unknown	Asthma	○ Yes ○ No ○ Unknown
Liver disease	○ Yes ○ No ○ Unknown		If Yes: Type of liver disease	○ Mild ○ Moderate or severe ○ Unknown	
Chronic kidney disease	○ Yes ○ No ○ Unknown		If Yes: Stage of chronic kidney disease	○ Stage 1 ○ Stage 2 ○ Stage 3a ○ Stage 3b ○ Stage 4 ○ Stage 5 ○ Unknown	
HIV	○ Yes ○ No ○ Unknown				
Is the patient on anti-retroviral therapy (ART)?	○ Yes ○ No ○ Unknown		If Yes: Specify ART	_____	
If HIV positive: CD4 count date	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]		If HIV positive: Most recent CD4 count (cells/ÂµL)	_____	
If HIV positive: Is HIV viral load detectable	○ Yes ○ No ○ Unknown		If Yes: Most recent HIV viral load (copies/mL)	_____	
HIV viral load date	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]				
Tuberculosis	○ Yes ○ No ○ Unknown	Chronic hepatitis B/C infection	○ Yes ○ No ○ Unknown	Chronic haematologic disease	○ Yes ○ No ○ Unknown
Rheumatologic disorder	○ Yes ○ No ○ Unknown	Malignant neoplasm	○ Yes ○ No ○ Unknown	Obesity	○ Yes ○ No ○ Unknown
Malnutrition	○ Yes ○ No ○ Unknown				
Diabetes mellitus	○ Yes ○ No ○ Unknown		If Yes:		
Diabetes mellitus type	○ Type 1 ○ Type 2 ○ Gestational diabetes ○ Unknown		End organ damage from diabetes	○ Yes ○ No ○ Unknown	
Ever smoked	○ Yes ○ No ○ Unknown		If Yes: Smoking status	○ Current smoker ○ Former Smoker	

Passive smoking (lives in same household as a smoker)	○ Yes ○ No ○ Unknown				
Transplant recipient	○ Yes ○ No ○ Unknown			If Yes: Specify transplanted organ(s)	☐ Lung ☐ Heart ☐ Kidney ☐ Liver ☐ Bone ☐ Hematopoietic stem cell ☐ Other _____
Primary immunodeficiency	○ Yes ○ No ○ Unknown	Chemotherapy	○ Yes ○ No ○ Unknown	Radiation therapy	○ Yes ○ No ○ Unknown
Long term or high-dose corticosteroid therapy	○ Yes ○ No ○ Unknown				
Other relevant comorbidity(s)	○ Yes ○ No ○ Unknown			If Yes:	_____
Active Hepatitis C	○ Yes ○ No ○ Unknown			Active Hepatitis B	○ Yes ○ No ○ Unknown

MEDICATION PRIOR TO THIS ADMISSION / PRESENTATION

Antiviral	○ Yes ○ No ○ Unknown	If Yes:	
Antiviral	☐ Favipiravir ☐ Ribavirin ☐ Other _____	Antiviral start date	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]
Number of days antivirals taken	_____		
Corticosteroid	○ Yes ○ No ○ Unknown	If Yes:	
Corticosteroid	☐ Dexamethasone ☐ Prednisolone/ Prednisone ☐ Other _____	Corticoteroid start date	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]
Number of days corticosteroid taken	_____	Dose of corticosteroid	_____
Antibiotics	○ Yes ○ No ○ Unknown	If Yes: Antibiotics	☐ Azithromycin ☐ Ceftriaxone ☐ Vancomycin ☐ Other _____
NSAIDs	○ Yes ○ No ○ Unknown	If Yes:	

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

VACCINATION

Vaccinated for COVID-19 (ever)	○ Yes ○ No ○ Unknown	If Yes: Date of most recent COVID-19 vaccine	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]
Vaccinated for seasonal influenza (ever)	○ Yes ○ No ○ Unknown	If Yes: Date of most recent seasonal influenza vaccine	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]
Vaccinated for pneumococcal disease	○ Yes ○ No ○ Unknown	If Yes: Date of most recent pneumococcal disease vaccine	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]
Vaccinated for shingles (ever)	○ Yes ○ No ○ Unknown	If Yes: Date of most recent shingles vaccine	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

PREGNANCY PRESENTATION

Pregnant	○ Yes ○ No ○ Unknown

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

INFANT (<12 MONTHS) OR POST-PARTUM BIRTH (<6 WEEKS)

Birth weight	_____ ○g ○lb	Preterm birth (< 37wk GA)	○ Yes ○ No ○ Unknown
Breastfed	○ Yes-currently breastfeeding ○ Yes-breastfeeding discontinued ○ No ○ Unknown	If Yes-breastfeeding discontinued: How long did breastfeeding last? (weeks)	_____

DAILY

DAILY ASSESSMENT

DATE OF ASSESSMENT	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]	Current level of care	○ Home confinement ○ Admitted to hospital ward for isolation only ○ Admitted to hospital ward for clinical care and/or treatment (and probably isolation) ○ High dependency unit (HDU) ○ Intensive care unit (ICU) ○ Unknown
Limitation of usual daily activities due to illness	○ Yes ○ No ○ Unknown		

SYMPTOMS: Indicate if experienced between 00:00 to 24:00 on day of assessment.

Did the patient report symptoms on this date?	○ Yes ○ No		If Yes, complete the form:		
Fever	○ Yes ○ No ○ Unknown	Chills or rigors	○ Yes ○ No ○ Unknown	Fatigue / malaise / lethargy	○ Yes ○ No ○ Unknown
Weakness	○ Yes ○ No ○ Unknown	Muscle aches (myalgia)	○ Yes ○ No ○ Unknown	Skin rash	○ Yes ○ No ○ Unknown
Back Pain	○ Yes ○ No ○ Unknown			Neck Pain	○ Yes ○ No ○ Unknown
Cough	○ Yes ○ No ○ Unknown			If Yes: Cough type	○ Non Productive ○ Productive ○ Haemoptysis ○ Unknown
Shortness of breath	○ Yes ○ No ○ Unknown	Chest pain	○ Yes ○ No ○ Unknown	Abdominal pain	○ Yes ○ No ○ Unknown
Diarrhoea	○ Yes ○ No ○ Unknown	Vomiting	○ Yes ○ No ○ Unknown	Nausea	○ Yes ○ No ○ Unknown
Anorexia	○ Yes ○ No ○ Unknown	Urinary retention	○ Yes ○ No ○ Unknown	Increased urination (polyuria)	○ Yes ○ No ○ Unknown
Bleeding (haemorrhage)	○ Yes ○ No ○ Unknown			If Yes:	

Severe bleeding (requires intervention)	○ Yes ○ No ○ Unknown	Specify bleeding site(s)	☐ GI tract ☐ Gums ☐ Intra-articular ☐ Intracranial ☐ Intramuscular (with compartment syndrome) ☐ Intraocular ☐ Intraspinal ☐ Nose ☐ Pericardial ☐ Other _____

Headache	○ Yes ○ No ○ Unknown	Photophobia	○ Yes ○ No ○ Unknown	Hazy / Blurred vision	○ Yes ○ No ○ Unknown
Seizures / convulsions	○ Yes ○ No ○ Unknown			Altered consciousness / confusion	○ Yes ○ No ○ Unknown
Other symptom(s)	○ Yes ○ No ○ 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?	○ Yes ○ No			If Yes:	
Hypothermia	○ Yes ○ No ○ Unknown			Cold / clammy peripheries	○ Yes ○ No ○ Unknown
Dehydration	○ Yes ○ No ○ Unknown			If Yes: Dehydration Status	○ Mild ○ Moderate ○ Severe
Oedema	○ Yes ○ No ○ Unknown	Reduced urine output	○ Yes ○ No ○ Unknown	Respiratory distress	○ Yes ○ No ○ Unknown
Lower chest wall indrawing	○ Yes ○ No ○ Unknown	Fast breathing (tachypnoea)	○ Yes ○ No ○ Unknown	Rapid heart rate (tachycardia)	○ Yes ○ No ○ Unknown
Peripheral cyanosis	○ Yes ○ No ○ Unknown	Ascites	○ Yes ○ No ○ Unknown	Palpable liver/Hepatomegaly	○ Yes ○ No ○ Unknown
Palpable spleen/splenomegaly	○ Yes ○ No ○ Unknown	Tender abdomen	○ Yes ○ No ○ Unknown	Jaundice	○ Yes ○ No ○ Unknown
Anaemia	○ Yes ○ No ○ Unknown	Cognitive impairment	○ Yes ○ No ○ Unknown	Agitation	○ Yes ○ No ○ Unknown
Subconjunctival haemorrhage	○ Yes ○ No ○ Unknown				

Other sign(s)	○ Yes ○ No ○ Unknown	If Yes:	_____

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

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

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

RESPIRATORY SUPPORT: Record all respiratory interventions given between 00:00 to 24:00 on day of assessment.			
Supplemental oxygen	○ Yes ○ No ○ Unknown	If Yes, complete the form:	
Oxygen saturation with supplemental oxygen (%)	_____	Nasal prongs	○ Yes ○ No ○ Unknown
Face mask	○ Yes ○ No ○ Unknown	High flow nasal oxygen	○ Yes ○ No ○ Unknown
Non-invasive ventilation	○ Yes ○ No ○ Unknown	If Yes: Type of non-invasive ventilation	○ CPAP ○ BIPAP ○ Unknown ○ Other
Invasive ventilation	○ Yes ○ No ○ Unknown		
Extracorporeal life support therapy (ECLS) / Extracorporeal membrane oxygenation (ECMO)	○ Yes ○ No ○ Unknown	If Yes: Type of ECLS / ECMO	○ Veno-venous (VV) ○ Veno-arterial (VA) ○ Unknown
Prone positioning	○ Yes ○ No ○ Unknown	If Yes: When was the prone positioning?	○ During invasive ventilation ○ Whilst self-ventilating ○ Unknown
Was PaO_2 measured today?	○ Arterial ○ Capillary ○ Venous ○ Unknown ○ Not done	If Arterial, Capillary, Venous:	
PaO2	_____ ○kPa ○mmHg	FiO2 at time of PaO2	_____ ○Fraction, 0.21-1.0 ○%, 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?	○ Yes ○ No ○ Unknown	If Yes, complete the form:			
ICU / ITU / HDU / Intermediate Care Unit admission	○ Yes ○ No ○ Unknown	Neuromuscular blocking agents	○ Yes ○ No ○ Unknown	Inhaled nitric oxide	○ Yes ○ No ○ Unknown
Tracheostomy inserted	○ Yes ○ No ○ Unknown				
Renal replacement therapy (RRT) or dialysis / hemofiltration	○ Yes ○ No ○ Unknown	If Yes: Type of renal replacement therapy (RRT) or dialysis / hemofiltration		○ Intermittent ○ Continuous ○ Unknown	
Any vasopressor / inotropic support	○ Yes ○ No ○ Unknown	If Yes:			

Reason for vasopressor / inotrope use	☐ Shock ☐ Persistent hypotension ☐ Other ☐ Unknown	Vasopressor / Inotropic support type	○ Dopamine < 5ug/kg/min OR dobutamine OR milrinone OR levosimendan ○ Dopamine 5-15ug/kg/min OR epinephrine(adrenaline) / norepinephrine(noradrenaline) <=0.1ug/kg/min OR vasopressin OR phenylephrine ○ Dopamine >15ug/kg/min OR epinephrine(adrenaline) / norepinephrine(noradrenaline) >0 .1ug/kg/min
Other advanced care intervention(s) or procedure(s)	○ Yes ○ No ○ Unknown	If Yes: Specify other advanced care intervention(s) or procedure(s)	_____

CLINICAL LABS

LABORATORY: HEMATOLOGY & BIOCHEMISTRY - RECORD THE VALUE FURTHEST FROM THE NORMAL RANGE BETWEEN 00:00 AND 24:00 ON THE DAY OF ASSESSMENT.					
Collection date	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]	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	Left shift present	○ No ○ Yes	Circulating immunoblasts (%)	_____
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)	_____	D-Dimer	_____ ○mg/L ○µg/L		
Total bilirubin	_____ ○µmol/L ○mg/dL	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)	_____ ○mg/L ○mg/dL		
Ferritin (µg/L or ng/mL)	_____	Lactate dehydrogenase (LDH) (U/L)		_____	
Random blood glucose	_____ ○mmol/L ○mg/dL ○g/L	HDL cholesterol	_____ ○mmol/L ○mg/dL	LDL cholesterol	_____ ○mmol/L ○mg/dL
Triglycerides	_____ ○mmol/L ○mg/dL	Blood Urea Nitrogen	_____ ○mmol/L ○mg/dL	Creatinine	_____ ○µmol/L ○mg/dL
Cystatin C (mg/L)	_____	Sodium (mmol/L or mEq/L)	_____	Potassium (mmol/L or mEq/L)	_____
Blood Lactate	_____ ○mmol/L ○mg/dL	Blood gas specimen type	○ Arterial ○ Capillary ○ Venous ○ Unknown	pH	_____
Bicarbonate (HCO3-) (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	_____ ○g/L ○g/dL		

VIROLOGY AND IMMUNOLOGY

Andes virus (ANDV) virology testing

Was RT-qPCR performed on venous blood?	○ Yes ○ No ○ Unknown		If Yes:		
Blood collection date and time	_____		Blood specimen type(s) used	☐ Buffy coat ☐ Plasma ☐ Whole blood (EDTA)	
RT-qPCR result in venous blood	○ Positive ○ Negative ○ Indeterminate ○ Pending/Unknown	RT-qPCR Ct value	_____	Viral load result	_____ ○Copies/mL ○log10 copies/mL
Was RT-qPCR performed on nasopharyngeal swab?	○ Yes ○ No ○ Unknown		If Yes:		
NP collection date and time	_____		RT-qPCR result in nasopharyngeal swab	○ Positive ○ Negative ○ Indeterminate ○ Pending/Unknown	
RT-qPCR Ct value	_____		Viral load result	_____ ○Copies/mL ○log10 copies/mL	
Was RT-qPCR performed on saliva?	○ Yes ○ No ○ Unknown		If Yes:		
Saliva collection date and time	_____		RT-qPCR result in saliva	○ Positive ○ Negative ○ Indeterminate ○ Pending/Unknown	
RT-qPCR Ct value	_____		Viral load result	_____ ↧Copies/mL ↧log10 copies/mL	
Was RT-qPCR performed on urine?	○ Yes ○ No ○ Unknown		If Yes:		
Urine collection date and time	_____		RT-qPCR result in urine	○ Positive ○ Negative ○ Indeterminate ○ Pending/Unknown	
RT-qPCR Ct value	_____		Viral load result	_____ ○Copies/mL ○log10 copies/mL	
Was RT-qPCR performed on semen?	○ Yes ○ No ○ Unknown		If Yes:		
Semen collection date and time	_____		RT-qPCR result in semen	○ Positive ○ Negative ○ Indeterminate ○ Pending/Unknown	
RT-qPCR Ct value	_____		Viral load result	_____ ○Copies/mL ○log10 copies/mL	

Was RT-qPCR performed on feces?	○ Yes ○ No ○ Unknown	If Yes:	
Feces collection date and time	_____	RT-qPCR result in feces	○ Positive ○ Negative ○ Indeterminate ○ Pending/Unknown
RT-qPCR Ct value	_____	Viral load result	_____ ○Copies/mL ○log10 copies/mL

Andes virus (ANDV) immunology testing

Was serology performed?	○ Yes ○ No ○ Unknown		If Yes:		
Collection date	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]		IgM result	○ Negative ○ Positive ○ Equivocal ○ Unknown	
IgM numeric value	_____ ○Index ○AU/mL ○U/mL ○DU ○OD ratio ○Titer ○Other	IgG result	○ Negative ○ Positive ○ Equivocal ○ Unknown	IgG numeric value	_____ ○Index ○AU/mL ○U/mL ○DU ○OD ratio ○Titer ○Other
Was virus genome sequencing was ordered/performed?	○ Yes ○ No ○ Unknown				

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	○ Antiviral ○ Corticosteroid ○ Immunomodulator ○ Analgesic ○ Antibiotic ○ Anticoagulant ○ Immunosuppressive drugs (non-steroid) ○ Inotropes / vasopressor ○ Intravenous immunoglobulin ○ Other ___________	○ Antiviral ○ Corticosteroid ○ Immunomodulator ○ Analgesic ○ Antibiotic ○ Anticoagulant ○ Immunosuppressive drugs (non-steroid) ○ Inotropes / vasopressor ○ Intravenous immunoglobulin ○ Other ___________	○ Antiviral ○ Corticosteroid ○ Immunomodulator ○ Analgesic ○ Antibiotic ○ Anticoagulant ○ Immunosuppressive drugs (non-steroid) ○ Inotropes / vasopressor ○ Intravenous immunoglobulin ○ Other ___________	○ Antiviral ○ Corticosteroid ○ Immunomodulator ○ Analgesic ○ Antibiotic ○ Anticoagulant ○ Immunosuppressive drugs (non-steroid) ○ Inotropes / vasopressor ○ Intravenous immunoglobulin ○ Other ___________	○ Antiviral ○ Corticosteroid ○ Immunomodulator ○ Analgesic ○ Antibiotic ○ Anticoagulant ○ Immunosuppressive drugs (non-steroid) ○ Inotropes / vasopressor ○ Intravenous immunoglobulin ○ Other ___________
Is this medication treating the disease?	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ 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	○ Oral ○ Subcutaneous ○ Inhaled ○ IV ○ Topical ○ Unknown ○ Other ___________	○ Oral ○ Subcutaneous ○ Inhaled ○ IV ○ Topical ○ Unknown ○ Other ___________	○ Oral ○ Subcutaneous ○ Inhaled ○ IV ○ Topical ○ Unknown ○ Other ___________	○ Oral ○ Subcutaneous ○ Inhaled ○ IV ○ Topical ○ Unknown ○ Other ___________	○ Oral ○ Subcutaneous ○ Inhaled ○ IV ○ Topical ○ Unknown ○ 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?	○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown

OUTCOME

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

Were any complications reported from the day of presentation to the day of discharge/outcome?	○ Yes ○ No		
Stroke / cerebrovascular accident	○ Yes ○ No ○ Unknown	If Yes: Date of stroke / cerebrovascular accident onset	_____
Encephalopathy	○ Yes ○ No ○ Unknown	If Yes: Date of encephalopathy onset	_____
Seizure	○ Yes ○ No ○ Unknown	If Yes: Date of seizure onset	_____
Encephalitis	○ Yes ○ No ○ Unknown	If Yes: Date of encephalitis onset	_____
Meningitis	○ Yes ○ No ○ Unknown	If Yes: Date of meningitis onset	_____
Cardiac ischaemia	○ Yes ○ No ○ Unknown	If Yes: Date of cardiac ischaemia onset	_____
Endocarditis	○ Yes ○ No ○ Unknown	If Yes: Date of endocarditis onset	_____
Cardiomyopathy	○ Yes ○ No ○ Unknown	If Yes: Date of cardiomyopathy onset	_____
Congestive heart failure	○ Yes ○ No ○ Unknown	If Yes: Date of congestive heart failure onset	_____
Cardiac arrhythmia	○ Yes ○ No ○ Unknown	If Yes: Date of cardiac arrhythmia onset	_____
Cardiac arrest	○ Yes ○ No ○ Unknown	If Yes: Date of cardiac arrest onset	_____
Myocarditis	○ Yes ○ No ○ Unknown	If Yes: Date of myocarditis onset	_____
Pericarditis	○ Yes ○ No ○ Unknown	If Yes: Date of pericarditis onset	_____
Pneumonia / pneumonitis	○ Yes ○ No ○ Unknown	If Yes:	

Date of pneumonia / pneumonitis onset	_____	Etiology of pneumonia	○ Viral ○ Bacterial ○ Fungal
Pneumothorax	○ Yes ○ No ○ Unknown	If Yes: Date of pneumothorax onset	_____
Pleural effusion	○ Yes ○ No ○ Unknown	If Yes: Date of pleural effusion onset	_____
Cryptogenic organising pneumonia (COP)	○ Yes ○ No ○ Unknown	If Yes: Date of cryptogenic organising pneumonia (COP) onset	_____
Bronchiolitis	○ Yes ○ No ○ Unknown	If Yes: Date of bronchiolitis onset	_____
Acute Respiratory Distress Syndrome (ARDS)	○ Yes ○ No ○ Unknown	If Yes: Date of acute respiratory distress syndrome (ARDS) onset	_____
Ascites	○ Yes ○ No ○ Unknown	If Yes: Date of ascites onset	_____
Pancreatitis	○ Yes ○ No ○ Unknown	If Yes: Date of pancreatitis onset	_____
Jaundice	○ Yes ○ No ○ Unknown	If Yes: Date of jaundice onset	_____
Liver dysfunction	○ Yes ○ No ○ Unknown	If Yes: Date of liver dysfunction onset	_____
Thromboembolism	○ Yes ○ No ○ Unknown	If Yes: Date of thromboembolism onset	_____
Pulmonary embolism (PE)	○ Yes ○ No ○ Unknown	If Yes: Date of pulmonary embolism (PE) onset	_____
Deep vein thrombosis (DVT)	○ Yes ○ No ○ Unknown	If Yes: Date of deep vein thrombosis (DVT) onset	_____
Other complication(s)	○ Yes ○ No ○ Unknown	If Yes:	_____

DIAGNOSIS

Primary diagnosis	○ Andes virus infection (hantavirus) ○ No disease / asymptomatic ○ Other _____	If Andes virus infection (hantavirus), Other:	
Type of diagnosis	☐ Clinical diagnosis ☐ Lab-confirmed ☐ Radiologically confirmed (e.g., chest X-ray, CT) ☐ Unknown ☐ Other	Any additional diagnosis?	○ Yes ○ No

SEVERITY ASSESMENT

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

OUTCOME

Isolation end date	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]		
Follow-up end reason	○ Completed per protocol ○ End of isolation ○ Withdrawal of consent ○ Lost to follow-up ○ Death ○ Investigator decision ○ Other _____	If Lost to follow-up, Withdrawal of consent:	
Date of last participant contact	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]	Date of consent withdrawal	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]
Reason for consent withdrawal	○ Participant decision ○ Safety concern ○ Other _____		
Date of clinical outcome	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]		

Outcome	○ Alive, never hospitalised ○ Discharged alive ○ Death ○ Discharged against medical advice ○ Palliative care ○ Still hospitalised ○ Transfer to other facility ○ Other _____	If Discharged alive, Still hospitalised, Transfer to other facility:	
Ability to self-care at discharge versus before illness	○ Same as before illness ○ Worse ○ Better ○ Unknown	If discharged alive: Oxygen therapy post-discharge treatment	○ Yes ○ No ○ 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?	_____