Sisters Hospitallers ENGLISH PROVINCE KCCR BNITM Bernhard Nocht Institute for Tropical Medicine	Page 1	☐ multiple choice ○ single choice |__| alphanumeric	**CLEAR** **Case Report Form – Enrolment** **Community**	Visit Bar Code

MeciA. Identification

A01	**Hospital-ID** |__| |__||__||__||__||__| / |__||__|	**Screening ID:**
A02	Age |__||__| years	
A03	Sex ○ male ○ female	
A04	Community_____	
A05	Date of interview |__||__| / |__||__| / |__||__| (dd/mm/yy)	
A06	Is the patient participating in another study? ○ no ○ yes □ *if yes*, which? _____	

C. Previous drug intake

C01	Was medication taken/given in last month? ○ no ○ yes ○ unknown □ *if yes*, what: *(please specify all medication names)* ☐ antibiotics _____ ☐ antimalarials: _____ ☐ NSAIDs: _____ ☐ others: _____

D. Immunization check

D01	Did the patient receive a Covid-19 vaccine ○ no ○ yes ○ unknown □ *if yes:* Number of doses received: |__|
D02	COVID-19 vaccine dose 1: Product name: ○ Sputnik ○ Pfizer-BioNTech ○ AstraZeneca ○ Janssen ○ Novavax ○ Covishield ○ Other: _____ ○ Unknown Date: |__||__| / |__||__| / |__||__| (dd/mm/yy)
	COVID-19 vaccine dose 2: Product name: ○ Sputnik ○ Pfizer-BioNTech ○ AstraZeneca ○ Janssen ○ Novavax ○ Covishield ○ Other: _____ ○ Unknown Date: |__||__| / |__||__| / |__||__| (dd/mm/yy)
	COVID-19 vaccine dose 3: Product name: ○ Sputnik ○ Pfizer-BioNTech ○ AstraZeneca ○ Janssen ○ Novavax ○ Covishield ○ Other: _____ ○ Unknown Date: |__||__| / |__||__| / |__||__| (dd/mm/yy)
	□ *If more than 3 doses:* Please enter the Product name and date of further vaccinations here:
D03	Source of information: ○ documented evidence (Vaccine card/vaccine passport/facility-based record/other) ○ recall

☐ multiple choice
◯ single choice
|__| alphanumeric

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E. Medical history: SARS-CoV-2 Infection

E01	Has the participant been infected / ill with SARS-CoV-2 / COVID-19 previously? ◯ no ◯ yes ◯ unknown ▯ *if yes*, how many times? |__||__| times ▯ *if yes*, please answer the following questions (one row for each single infection):		
	How many months ago?	What is the highest level of care received?	How was your infection/illness confirmed?
E01.1	◯ <1 ◯ 1-<3 ◯ 3-<6 ◯ 6-<12 ◯ ⩾12 ◯ can't recall	◯ Admitted to the hospital ◯ Self-care/Over the counter ◯ Outpatient ◯ Telemedicine ◯ Community facility/CHPS ◯ Unknown	☐ Nose &/ throat swab test ☐ Symptoms assessed by a doctor ☐ Blood sample ☐ Symptoms assessed by a non-medical professional (pharmacist, traditional healer, family member) ☐ self-suspicion due to contact with a suspected/confirmed covid-19 case ☐ Other, please specify:
E01.2	◯ <1 ◯ 1-<3 ◯ 3-<6 ◯ 6-<12 ◯ ⩾12 ◯ can't recall	◯ Admitted to the hospital ◯ Self-care/Over the counter ◯ Outpatient ◯ Telemedicine ◯ Community facility/CHPS ◯ Unknown	☐ Nose &/ throat swab test ☐ Symptoms assessed by a doctor ☐ Blood sample ☐ Symptoms assessed by a non-medical professional (pharmacist, traditional healer, family member) ☐ self-suspicion due to contact with a suspected/confirmed covid-19 case ☐ Other, please specify:
E01.3	◯ <1 ◯ 1-<3 ◯ 3-<6 ◯ 6-<12 ◯ ⩾12 ◯ can't recall	◯ Admitted to the hospital ◯ Self-care/Over the counter ◯ Outpatient ◯ Telemedicine ◯ Community facility/CHPS ◯ Unknown	☐ Nose &/ throat swab test ☐ Symptoms assessed by a doctor ☐ Blood sample ☐ Symptoms assessed by a non-medical professional (pharmacist, traditional healer, family member) ☐ self-suspicion due to contact with a suspected/confirmed covid-19 case ☐ Other, please specify:
E01.4			
E01.5			

E. Medical history

E02	▯ *if female*, are you pregnant? ◯ no ◯ yes ▯ *if yes,* which week according to USG or LMP: |__||__| week
E03	Onset date of the current illness |__||__| / |__||__| / |__||__| (dd/mm/yy)
E04	Was the patient admitted to any hospital in the last 6 months ◯ no ◯ yes ▯ *if yes*, how many times? |__||__| times ▯ *if yes*, specify the reason(s): _____
E05	Did the patient seek medical care in the last 6 months (excluding admissions)? ▯ *if yes*, how many times? |__||__| times ▯ *if yes*, specify the reason(s): _____

☐ multiple choice
◯ single choice
|__| alphanumeric

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G. Health TODAY

G01	Was the assessment completed? ◯ no ◯ yes
	Under each heading, please tick the ONE box that best describes your health <u>TODAY</u>.
G02	**MOBILITY** ◯ I have no problems in walking about ◯ I have slight problems in walking about ◯ I have moderate problems in walking about ◯ I have severe problems in walking about ◯ I am unable to walk about
G03	**USUAL ACTIVITIES *(e.g. work, study, housework, family or leisure activities)*** ◯ I have no problems doing my usual activities ◯ I have slight problems doing my usual activities ◯ I have moderate problems doing my usual activities ◯ I have severe problems doing my usually activities ◯ I am unable to do my usual activities
G04	**ANXIETY** ◯ I am not anxious ◯ I am slightly anxious ◯ I am moderately anxious ◯ I am severely anxious ◯ I am extremely anxious
G05	**SELF-CARE** ◯ I have no problems washing or dressing myself ◯ I have slight problems washing or dressing myself ◯ I have moderate problems washing or dressing myself ◯ I have severe problems washing or dressing myself ◯ I am unable to wash or dress myself
G06	**PAIN / DISCOMFORT** ◯ I have no pain or discomfort ◯ I have slight pain or discomfort ◯ I have moderate pain or discomfort ◯ I have severe pain or discomfort ◯ I have extreme pain or discomfort

L. Remarks

_____

_____

_____

_____

_____

_____

M. Responsibilities

Field worker who filled out the questionnaire:

Initials |__||__||__| Date |__||__|/|__||__|/|__||__| (dd/mm/yy)

Study Doctor who checked the questionnaire:

Initials |__||__||__| Date |__||__|/|__||__|/|__||__| (dd/mm/yy)

Data staff who entered the data in the database:

Initials |__||__||__| Date |__||__|/|__||__|/|__||__| (dd/mm/yy)

☐ multiple choice
◯ single choice
|__| alphanumeric
Grey sections to be completed by study nurse

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Case Report Form – Enrolment
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A. Identification

A01	**Hospital-ID** |__||__||__||__||__||__| / |__||__|	**Screening ID:**
A02	Age |__||__| years	
A03	Sex ◯ male ◯ female	
A04	Community_____	
A05	Date of interview |__||__| / |__||__| / |__||__| (dd/mm/yy)	
A06	Is the patient participating in another study? ◯ no ◯ yes ▯ *if yes*, which? _____	

B. General status/Vital signs

B01	Weight |__||__| . |__| kg Height |__||__||__| cm
B02	Were vital signs collected? ◯ no ◯ yes ◯ NA
B03	Blood Pressure (mmHg): |__||__||__|/|__||__| ◯ not done
B04	Temperature (°C): |__||__|.|__| ◯ Oral ◯ Axillary ◯ Rectal ◯ Tympanic ◯ Temporal ◯ not done
B05	Heart Rate: |__||__||__|(beats/min) ◯ not done
B06	Respiratory Rate: |__||__|(breath/min) ◯ not done
B07	Blood oxygen saturation (SpO2) – resting: |__||__||__| % ◯ not done Time measurement performed: |__||__|:|__||__| (hh:mm) Assessment done with ◯ Room Air ◯ Oxygen Therapy

C. Previous drugs intake

C01	Was medication taken/given in last month? ◯ no ◯ yes ◯ unknown ▯ *if yes*, what: *(please specify all medication names)* ☐ antibiotics _____ ☐ antimalarials: _____ ☐ NSAIDs: _____ ☐ others: _____

D. Immunization check

D01	Did the patient receive a Covid-19 vaccine ◯ no ◯ yes ◯ unknown ▯ *if yes:* Number of doses received: |__|
D02	COVID-19 vaccine dose 1: Product name: ◯ Sputnik ◯ Pfizer-BioNTech ◯ AstraZeneca ◯ Janssen ◯ Novavax ◯ Covishield ◯ Other: _____ ◯ Unknown Date: |__||__| / |__||__| / |__||__| (dd/mm/yy)
	COVID-19 vaccine dose 2: Product name: ◯ Sputnik ◯ Pfizer-BioNTech ◯ AstraZeneca ◯ Janssen ◯ Novavax ◯ Covishield ◯ Other: _____ ◯ Unknown Date: |__||__| / |__||__| / |__||__| (dd/mm/yy)
	COVID-19 vaccine dose 3: Product name: ◯ Sputnik ◯ Pfizer-BioNTech ◯ AstraZeneca ◯ Janssen ◯ Novavax ◯ Covishield ◯ Other: _____ ◯ Unknown Date: |__||__| / |__||__| / |__||__| (dd/mm/yy)
	▯ *If more than 3 doses:* Please enter the Product name and date of further vaccinations here:
D03	Source of information: ◯ documented evidence (Vaccine card/vaccine passport/facility-based record/other) ◯ recall

☐ multiple choice
◯ single choice
|__| alphanumeric
Grey sections to be completed by study nurse

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E. Medical history: SARS-CoV-2 Infection

E01	Has the participant been infected / ill with SARS-CoV-2 / COVID-19 previously? ◯ no ◯ yes ◯ unknown ▯ *if yes*, how many times? |__||__| times ▯ *if yes*, please answer the following questions (one row for each single infection):		
	How many months ago?	What is the highest level of care received?	How was your infection/illness confirmed?
E01.1	◯ <1 ◯ 1-<3 ◯ 3-<6 ◯ 6-<12 ◯ ⩾12 ◯ can't recall	◯ Admitted to the hospital ◯ Self-care/Over the counter ◯ Outpatient ◯ Telemedicine ◯ Community facility/CHPS ◯ Unknown	☐ Nose &/ throat swab test ☐ Symptoms assessed by a doctor ☐ Blood sample ☐ Symptoms assessed by a non-medical professional (pharmacist, traditional healer, family member) ☐ Self-suspicion due to contact with a suspected/confirmed covid-19 case ☐ Other, please specify:
E01.2	◯ <1 ◯ 1-<3 ◯ 3-<6 ◯ 6-<12 ◯ ⩾12 ◯ can't recall	◯ Admitted to the hospital ◯ Self-care/Over the counter ◯ Outpatient ◯ Telemedicine ◯ Community facility/CHPS ◯ Unknown	☐ Nose &/ throat swab test ☐ Symptoms assessed by a doctor ☐ Blood sample ☐ Symptoms assessed by a non-medical professional (pharmacist, traditional healer, family member) ☐ self-suspicion due to contact with a suspected/confirmed covid-19 case ☐ Other, please specify:
E01.3	◯ <1 ◯ 1-<3 ◯ 3-<6 ◯ 6-<12 ◯ ⩾12 ◯ can't recall	◯ Admitted to the hospital ◯ Self-care/Over the counter ◯ Outpatient ◯ Telemedicine ◯ Community facility/CHPS ◯ Unknown	☐ Nose &/ throat swab test ☐ Symptoms assessed by a doctor ☐ Blood sample ☐ Symptoms assessed by a non-medical professional (pharmacist, traditional healer, family member) ☐ self-suspicion due to contact with a suspected/confirmed covid-19 case ☐ Other, please specify:
E01.4			
E01.5			

☐ multiple choice
◯ single choice
|__| alphanumeric
Grey sections to be completed by study nurse

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E. Medical history: Others

E02	▯ *if female*, are you pregnant? ◯ no ◯ yes ▯ *if yes,* which week according to USG or LMP: |__||__| week
E03	Onset date of the current illness |__||__| / |__||__| / |__||__| (dd/mm/yy)
E04	Was the patient admitted to any hospital in the last 6 months ◯ no ◯ yes ▯ *if yes*, how many times? |__||__| times ▯ *if yes*, specify the reason(s): _____ _____
E05	Did the patient seek medical care in the last 6 months (excluding admissions)? ◯ no ◯ yes ▯ *if yes*, how many times? |__||__| times ▯ *if yes*, specify the reason(s): _____ _____

F. Comorbidities

		Experienced			Year started	Severity			
No.	Comorbidities			.	(yyyy)				not
	F01 Cardiovascular disease and metabolic disorder								
F01a	Hypertension	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F01b	Coronary artery disease	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F01c	Heart failure	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F01d	Congenital heart disease	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F01e	Acquired Cardiomyopathy (e.g. prolonged QT- interval, QT arrythmia, heart failure, MI, bradycardia < 50 bpm)	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F01f	Stroke	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F01g	Prior Heart Surgery	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F01h	Pulmonary hypertension	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F01i	Diabetes Mellitus (type 1)	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F01j	Diabetes Mellitus (type 2)	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F01k	Diabetes Mellitus (gestational)	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F01l	Micro angiopathy	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F01m	Macro-angiopathy	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
	F02 Respiratory disorder								
F02a	Asthma	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F02b	Cystic fibrosis	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F02c	COPD	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F02d	Emphysema	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F02e	Chronic bronchitis	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯

☐ multiple choice
◯ single choice
|__| alphanumeric
Grey sections to be completed by study nurse

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F. Comorbidities

No.	Comorbidities	Experienced			Year started (yyyy)	Severity			
									not
	F03 Renal disorder								
F03a	Renal disease with dialysis	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F03b	Renal disease without dialysis	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
	F04 Genetic disease and other severe illnesses								
F04a	Sickle cell disease	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F04b	Thalassemia	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F04c	Metastatic cancer	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F04d	Haematopoietic stem cell transplantation	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F04e	Cirrhosis	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F04f	Cancer chemotherapy	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F04g	Immunosuppressive treatment (biotherapy and/or corticosteroid))	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
F04h	Uncontrolled HIV or known CD4 < 200/mm3	◯	◯	◯	|__||__||__||__|	◯	◯	◯	◯
	F05 Other, please specifiy								
F05a					|__||__||__||__|	◯	◯	◯	◯
F05b					|__||__||__||__|	◯	◯	◯	◯
F05c					|__||__||__||__|	◯	◯	◯	◯

G. Health before illness

G01	Was the assessment completed? ◯ no ◯ yes
	Under each heading, please tick the ONE box that best describes your health before your illness.
G02	**MOBILITY** ◯ I had no problems in walking about ◯ I had slight problems in walking about ◯ I had moderate problems in walking about ◯ I had severe problems in walking about ◯ I was unable to walk about
G03	**USUAL ACTIVITIES *(e.g. work, study, housework, family or leisure activities)*** ◯ I had no problems doing my usual activities ◯ I had slight problems doing my usual activities ◯ I had moderate problems doing my usual activities ◯ I had severe problems doing my usually activities ◯ I was unable to do my usual activities
G04	**ANXIETY** ◯ I was not anxious ◯ I was slightly anxious ◯ I was moderately anxious ◯ I was severely anxious ◯ I was extremely anxious
G05	**SELF-CARE** ◯ I had no problems washing or dressing myself ◯ I had slight problems washing or dressing myself ◯ I had moderate problems washing or dressing myself ◯ I had severe problems washing or dressing myself ◯ I was unable to wash or dress myself
G06	**PAIN / DISCOMFORT** ◯ I had no pain or discomfort ◯ I had slight pain or discomfort ◯ I had moderate pain or discomfort ◯ I had severe pain or discomfort ◯ I had extreme pain or discomfort

☐ multiple choice
◯ single choice
|__| alphanumeric
Grey sections to be completed by study nurse

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H. Respiratory Symptoms

H01	Was the assessment completed? ◯ no ◯ yes		
H02	Assessment date: |__||__| / |__||__| / |__||__| (dd/mm/yy)		
	Symptoms	**Status**	**Onset of symptom** (dd/mm/yy)
H03	Fever	◯ no ◯ yes ◯ not done	|__||__|/|__||__|/|__||__|
H04	Cough	◯ no ◯ yes ◯ not done	|__||__|/|__||__|/|__||__|
H05	Shortness of breath	◯ no ◯ yes ◯ not done	|__||__|/|__||__|/|__||__|
H06	Sore throat	◯ no ◯ yes ◯ not done	|__||__|/|__||__|/|__||__|
H07	Runny nose (Rhinorrhoea)	◯ no ◯ yes ◯ not done	|__||__|/|__||__|/|__||__|
H08	Loss of smell (Anosmia)	◯ no ◯ yes ◯ not done	|__||__|/|__||__|/|__||__|
H09	Loss of taste (Ageusia)	◯ no ◯ yes ◯ not done	|__||__|/|__||__|/|__||__|
H10	Muscle aches (Myalgia)	◯ no ◯ yes ◯ not done	|__||__|/|__||__|/|__||__|
H11	Diarrhoea	◯ no ◯ yes ◯ not done	|__||__|/|__||__|/|__||__|
H12	Vomiting / Nausea	◯ no ◯ yes ◯ not done	|__||__|/|__||__|/|__||__|
H13	Headache	◯ no ◯ yes ◯ not done	|__||__|/|__||__|/|__||__|
H14	Fatigue / Malaise	◯ no ◯ yes ◯ not done	|__||__|/|__||__|/|__||__|
H15	Skin rash	◯ no ◯ yes ◯ not done	|__||__|/|__||__|/|__||__|
H16	Conjunctivitis	◯ no ◯ yes ◯ not done	|__||__|/|__||__|/|__||__|
H17	Others, please specify:		|__||__|/|__||__|/|__||__|

I. Ventilation

I01	☐ *if H05 'Shortness of breath'=yes*: Was the mMRC DYSPNEA completed? ◯ no ◯ yes ◯ NA		
I02	**I am now asking you about your respiration:** [mMRC dyspnea grade] **How would you rate your respiration? Would you say, ...**	**... before acute illness ?**	**... Today?**
I03	...'I only get breathless on strenuous exercise'?	◯ no ◯ yes	◯ no ◯ yes
I04	... 'I get short of breath when hurrying on level ground or walking up a slight hill'?	◯ no ◯ yes	◯ no ◯ yes
I05	... 'On level ground, I walk slower than other people the same age because of breathlessness or I have to stop for breath when walking at my own pace'?	◯ no ◯ yes	◯ no ◯ yes
I06	... 'I stop for breath after walking 100m or after a few minutes on level ground'?	◯ no ◯ yes	◯ no ◯ yes
I07	... 'I am too breathless to leave the house or I am breathless when dressing'?	◯ no ◯ yes	◯ no ◯ yes

J. Suspected diagnoses (on admission/OPD)

J01	Does the patient have COVID-19? ◯ no ◯ yes ◯ unknown ☐ *if yes*, severity: ◯ mild ◯ moderate ◯ severe
J02	Does the patient have another infection diagnosed? ◯ no ◯ yes ◯ unknown ☐ *if yes*, which?: _____
J03	Does the patient have suspected malaria? ◯ no ◯ yes ◯ unknown ☐ *if yes*, is it severe malaria? ◯ no ◯ yes ◯ unknown
J04	Result of SARS CoV 2 **PCR (not biofire)** ◯ positive ◯ negative ◯ NA
J05	Other suspected diagnosis: _____ _____ _____

☐ multiple choice
○ single choice
|__| alphanumeric
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[If the patient was admitted to the hospital, please fill in the hospitalisation form and follow up until discharge]

L. Remarks

_____

_____

_____

_____

_____

_____

M. Responsibilities

Study nurse who filled in the D0 questionnaire:

Initials |__||__||__| Date |__||__|/|__||__|/|__||__| (dd/mm/yy)

Doctor who filled in the D0 questionnaire:

Initials |__||__||__| Date |__||__|/|__||__|/|__||__| (dd/mm/yy)

Study nurse/ staff who performed the bedside tests:

Initials |__||__||__| Date |__||__|/|__||__|/|__||__| (dd/mm/yy)

Study Doctor who checked the questionnaire:

Initials |__||__||__| Date |__||__|/|__||__|/|__||__| (dd/mm/yy)

Data staff who entered the data in the database:

Initials |__||__||__| Date |__||__|/|__||__|/|__||__| (dd/mm/yy)

Data review who reviewed the data in the database:

Initials |__||__||__| Date |__||__|/|__||__|/|__||__| (dd/mm/yy)

Sisters Hospitallers ENGLISH PROVINCE KCCR BNITM Bernhard Nocht Institute for Tropical Medicine	Page 1	**CLEAR** **Case Report Form – Recruitment Review** **Community – Healthy controls**	Participant ID |__||__||__|- |__||__||__||__| -|__||__|	Screening ID |__||__||__|-|__||__||__|- |__||__||__||__|

Inclusion criteria

Patient 16 years old or older?	◯ no	◯ yes	☐ *if NO*☐EXCLUSION
Does the patient come from the catchment area AND is likely available during the whole follow up?	◯ no	◯ yes	☐ *if NO*☐EXCLUSION
Healthy individual (according to pre-screening sheet)	◯ no	◯ yes	☐ *if NO*☐EXCLUSION
Informed consent given?	◯ no	◯ yes	☐ *if NO*☐EXCLUSION

Screening of healthy participants

Date of screening: |__||__|/|__||__|/|__||__|(dd/mm/yy)			
Nasal swab taken?	◯ yes	◯ no	☐*Ag-RDT*
Ag-RDT Test result:	◯ positive	◯ negative	◯ invalid
Finger prick taken?	◯ yes	◯ no	☐*IgG-RDT, IgM-RDT*
IgG-RDT Test result:	◯ positive	◯ negative	◯ invalid
IgM-RDT Test result:	◯ positive	◯ negative	◯ invalid
Ag-RDT (-) AND IgG-RDT (-) AND IgM-RDT (-) Ag-RDT (-) AND IgG-RDT (+) AND IgM-RDT (-) Ag-RDT (+) OR IgM-RDT (+)			◯ ***SERONEGATIVE (HEALTHY)*** ◯ ***SEROPOSITIVE (HEALTHY)*** ◯ ***PERFORM MALARIA RDT***
Finger prick for Malaria?	◯ yes	◯ no	☐*Mal-RDT*
Mal-RDT result:	◯ positive ◯ negative ◯ invalid		☐ ***CO-INFECTION COHORT*** ☐ ***SCREENING FAILURE*** ☐ ***SCREENING FAILURE***

Inclusion HEALTHY CONTROL

Please allocate a Participant ID and stick the label into the header!	|__||__||__|- |__||__||__||__||__| -|__||__|
Participant ID of matching seropositive CASE	

Enrolment HEALTHY CONTROL

Study flow		
D0	Recruitment	05_02_CLEAR_D0_CRF_Healthy 05_10_CLEAR_Schedule
M1, M6, M13	Household visits: collection of Heparin blood for ELISA Socioeconomic Questionnaire (M1)	05_07_CLEAR_FU_MonthlyTImodule1 05_08_CLEAR_FU_MonthlyTImodule2 05_06_CLEAR_CRF_SEP_HHvisit 05_09_CLEAR_FU_MedicationUse
M2-M12\M6	Monthly telephone interview	05_07_CLEAR_FU_MonthlyTImodule1 05_08_CLEAR_FU_MonthlyTImodule2 05_09_CLEAR_FU_MedicationUse
END OF FOLLOW UP		

CLEAR
Case Report Form – Recruitment Review
Community – Healthy controls

Participant ID |__||__||__|-|__||__||__||__|-|__||__|

Screening ID |__||__||__|-|__||__||__|-|__||__||__||__|

Co-Infection Cohort (reallocation of participant)

Is the participant reporting Covid-like symptoms (at any time during the follow up)?
◯ yes ◯ no

Date: |__||__|/|__||__|/|__||__| (dd/mm/yy)

Samples taken

Nasal swab taken? ◯ yes ◯ no ☐ *Ag-RDT*

Ag-RDT result ◯ positive ☐ ***PERFORM MALARIA RDT***
◯ negative ☐ ***REGULAR FOLLOW-UP***

Screening for Co-Infection Cohort

Finger prick for Malaria? ◯ yes ◯ no ☐ *Mal-RDT*

Mal-RDT result: ◯ positive ☐ ***CO-INFECTION COHORT***
◯ negative ☐ ***REGULAR FOLLOW-UP***

Enrolment Co-Infection cohort

In case the participant was a healthy control before, please enrol the person again:

☐ *only if formerly control:* Please allocate a new Screening and Participant ID	Screening ID |__||__||__|-|__||__||__|-|__||__||__||__|	Participant ID |__||__||__|-|__||__||__||__||__|-|__||__|

Samples taken

EDTA blood taken ◯ yes ◯ no
Heparin blood taken ◯ yes ◯ no
Nasopharyngeal swab taken? ◯ yes ◯ no ☐PCR

Study flow

D0	Recruitment:	05_02_CLEAR_D0_CRF_Healthy 05_10_CLEAR_Schedule
D1-D28	☐ *if admitted to the ward:* Follow up until discharge:	05_05_CLEAR_Hosp_CRF
D1-D28	Daily telephone interview or follow up at the hospital if inpatient,	05_03_CLEAR_FU_DailyInterview 05_04_CLEAR_FU_DailyLog 05_09_CLEAR_FU_MedicationUse
M1/M6/M13	Household visit: collection of Heparin blood for ELISA Socioeconomic Questionnaire (M1)	05_07_CLEAR_FU_MonthlyTImodule1 05_08_CLEAR_FU_MonthlyTImodule2 05_06_CLEAR_CRF_SEP_HHvisit (M1) 05_09_CLEAR_FU_MedicationUse
M2-M12\M6	Monthly telephone interview	05_07_CLEAR_FU_MonthlyTImodule1 05_08_CLEAR_FU_MonthlyTImodule2 05_09_CLEAR_FU_MedicationUse

END OF FOLLOW UP

Sisters Hospitallers ENGLISH PROVINCE | KCCR | BNITM Bernhard Nocht Institute for Tropical Medicine

CLEAR
Recruitment Review Form
St. Francis Xavier Hospital

Participant ID |__||__||__|-|__||__||__||__||__|-|__||__|

Screening ID |__||__||__|-|__||__||__||__||__|-|__||__|

Inclusion criteria

Patient 16 years old or older?	◯ no	◯ yes	→ *if NO*→EXCLUSION
Is the patient suspected of a respiratory infection?	◯ no	◯ yes	→ *if NO*→EXCLUSION
Does the patient come from the catchment area AND is likely available during the whole follow up?	◯ no	◯ yes	→ *if NO*→EXCLUSION
Informed consent given?	◯ no	◯ yes	→ *if NO*→EXCLUSION

Pre-screening

Date of pre-screening: |__||__|/|__||__|/|__||__|(dd/mm/yy)

Place of pre-screening: ◯ Hospital ◯ Satellite centre

→ *if hospital:* ◯ IPD ◯ OPD ◯ Emergency department

→ *if satellite centre:* Which? _____

Is the patient **admitted** to the hospital (at least for one night)? ◯ yes ◯ no

Date and time of admission:

|__||__|/|__||__|/|__||__|, |__||__|:|__||__| (dd/mm/yy, hh:mm)

Screening of symptomatic patients

Nasal swab taken?	◯ yes	◯ no	→*Ag-RDT*
Ag-RDT Test result:	◯ positive	◯ negative	◯ invalid
Finger prick taken?	◯ yes	◯ no	→*IgG-RDT, IgM-RDT*
IgG-RDT Test result:	◯ positive	◯ negative	◯ invalid
IgM-RDT Test result:	◯ positive	◯ negative	◯ invalid

IgG-RDT (+) OR IgM-RDT (+) ◯ ***Seropositive***

IgG-RDT (-) AND IgM-RDT (-) ◯ ***Seronegative***

→ *If patient is not admitted:* ***Please notify call centre for daily follow up!***

Inclusion

→ *if included:* **Participant ID**	

Samples taken

EDTA blood taken	◯ yes	◯ no	
Heparin blood taken	◯ yes	◯ no	
Nasopharyngeal swab taken?	◯ yes	◯ no	→PCR (*Biofire test panel)*
Nasopharyngeal swab taken?	◯ yes	◯ no	→Bacteriology

Enrolment

Study flow		
D0	Recruitment:	05_02_CLEAR_D0_CRF_hospital 05_10_CLEAR_Schedule
D1-D28	→ *if admitted to the ward:* Follow up until discharge:	05_05_CLEAR_Hosp_CRF
D1-D2	Daily telephone interview or follow up at the hospital if inpatient Symptoms and treatment diary → *until 48h after disappearance of symptoms*	05_03_CLEAR_FU_DailyInterview 05_04_CLEAR_FU_DailyLog 05_09_CLEAR_FU_MedicationUse

Matching

Age group: ◯ 18-30 ◯ >30-50 ◯ >50

Matching partner identified within 2 days?

◯ yes → please, note the matching **Participant ID**

◯ no → *if admitted to the hospital:*

Biofire performed? ◯ yes →**SCREENING FAILURE**

◯ no →**AMU** (NO Biofire!)

→ *if not admitted*:

Seronegative: →**SCREENING FAILURE**

Seropositive: Further follow up (for matching to community controls within 15 days)?

◯ yes **Regular follow up**

◯ no **SCREENING FAILURE**

Participant ID (of matching partner) |__||__||__|-|__||__||__||__||__|-|__||__|

Final enrolment into CLEAR (Seropositive or Seronegative)

Study flow		
D1-D28	Daily telephone interview or follow up at the hospital if inpatient Symptoms and treatment diary → *until 48h after disappearance of symptoms*	05_03_CLEAR_FU_DailyInterview 05_04_CLEAR_FU_DailyLog 05_09_CLEAR_FU_MedicationUse
After final assignment to study group		
M1	Household visit: Socioeconomic Questionnaire (M1)	05_07_CLEAR_FU_MonthlyTImodule1 05_08_CLEAR_FU_MonthlyTImodule2 05_06_CLEAR_CRF_SEP_HHvisit 05_09_CLEAR_FU_MedicationUse
M2-M13	Monthly telephone interview	05_07_CLEAR_FU_MonthlyTImodule1 05_08_CLEAR_FU_MonthlyTImodule2 05_09_CLEAR_FU_MedicationUse
M1/M6/M13	Collection of Heparin blood for ELISA	

CLEAR
Recruitment Review Form
St. Francis Xavier Hospital

Participant ID
|__||__||__|-
|__||__||__||__|
-|__||__|

Screening ID
|__||__||__|-
|__||__||__||__|
-|__||__|

END OF FOLLOW UP

Sisters Hospitallers ENGLISH PROVINCE / KCCR / BNITM Bernhard Nocht Institute for Tropical Medicine	**CLEAR** **Follow up – Daily Interview**	Participant ID

A. Follow up information

A01	First date of follow up	|__||__| / |__||__| / |__||__| (dd/mm/yy)

B. Symptoms since last contact ***please add another sheet if this one is full***

No.	Are you experiencing any of the following?	Day __	Day __	Day __	Day __	Day __	Day __	Day __
B01	Any symptoms experienced?	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
	if yes, please probe for the whole list of symptoms:							
B01a	Fever ≥ 38°C	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
B01b	Chills	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
B01c	Runny nose	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
B01d	Cough	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
B01e	Sore throat	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
B01f	Shortness of breath	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
B01g	Loss of sense of smell	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
B01h	Distorted sense of taste	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
B01i	Muscle pain	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
B01j	Diarrhoea	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
B01k	Vomiting/Nausea	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
B01l	Headache	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
B01m	Tiredness or malaise	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
B01n	Skin rash or skin ulcer	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
B01o	Pink eye	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
B01p	Other[1]:	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
B01q	Other[2]:	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
B01r	Other[3]:	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
B02	Remarks							
B03	**Did the participant have symptoms in the last 48 hours?**	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
	if no: the daily follow up phase is over after the interview!							

C. Health care provider since last contact

No.	Question	Day __	Day __	Day __	Day __	Day __	Day __	Day __
C01	Have you taken any medications for your current illness?	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
	if yes, please probe for any medication taken (e.g. tablets intake, etc.): ***'Medication use'***							
C02	Have you sought care from a traditional healer?	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
C02a	***if yes:*** Any measure indicated from there? (e.g. *herbal tea)*	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
C02b	*if yes*, please specify:							
C03	Have you used any therapy due to health problems, since the last time we were in contact?	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
	if yes, please probe for any measurements taken (e.g. nebulization, physiotherapy, massage, heat therapy, etc.): ***'Medication use'***							
D01	Interviewer initials	|__||__||__|	|__||__||__|	|__||__||__|	|__||__||__|	|__||__||__|	|__||__||__|	|__||__||__|

Sisters Hospitallers ENGLISH PROVINCE / KCCR BNITM Bernhard Nocht Institute for Tropical Medicine	**CLEAR** **Follow up – Daily Log**	Participant ID

A. Follow up information

A01	First date of Follow up	|__||__| / |__||__| / |__||__| (dd/mm/yy)
A02	Identification:	
A03	Telephone number:	

B. Termination of daily interviews

B01	Last date	|__||__| / |__||__| / |__||__| (dd/mm/yy)
B02	Outcome	◯ Follow up for 48 hours without symptoms ◯ Follow up completed (up to day 28) ◯ Withdrawal
B03	Telephone interviewer:	|__||__||__| (initials)

C. Protocol of telephone interviews I [Please add another protocol page after 7 days]

Day	Date and Interviewer initials	Time of calls	Outcome (after 3 trials)	Daily Interview done?	Medication Use updated?	End time
01	|__||__|/|__||__|/|__||__| |__||__||__|	1.|__||__|:|__||__| 2.|__||__|:|__||__| 3.|__||__|:|__||__|	◯ P. reached ◯ P. not reached ◯ Call interrupted ◯ P. not willing	◯ no ◯ yes ▯ *if no,* why? _____	◯ no ◯ yes ▯ *if no,* why? _____	|__||__|:|__||__| Symptoms? ◯ no ◯ yes
02	|__||__|/|__||__|/|__||__| |__||__||__|	1.|__||__|:|__||__| 2.|__||__|:|__||__| 3.|__||__|:|__||__|	◯ P. reached ◯ P. not reached ◯ Call interrupted ◯ P. not willing	◯ no ◯ yes ▯ *if no,* why? _____	◯ no ◯ yes ▯ *if no,* why? _____	|__||__|:|__||__| Symptoms? ◯ no ◯ yes
03	|__||__|/|__||__|/|__||__| |__||__||__|	1.|__||__|:|__||__| 2.|__||__|:|__||__| 3.|__||__|:|__||__|	◯ P. reached ◯ P. not reached ◯ Call interrupted ◯ P. not willing	◯ no ◯ yes ▯ *if no,* why? _____	◯ no ◯ yes ▯ *if no,* why? _____	|__||__|:|__||__| Symptoms? ◯ no ◯ yes
04	|__||__|/|__||__|/|__||__| |__||__||__|	1.|__||__|:|__||__| 2.|__||__|:|__||__| 3.|__||__|:|__||__|	◯ P. reached ◯ P. not reached ◯ Call interrupted ◯ P. not willing	◯ no ◯ yes ▯ *if no,* why? _____	◯ no ◯ yes ▯ *if no,* why? _____	|__||__|:|__||__| Symptoms? ◯ no ◯ yes
05	|__||__|/|__||__|/|__||__| |__||__||__|	1.|__||__|:|__||__| 2.|__||__|:|__||__| 3.|__||__|:|__||__|	◯ P. reached ◯ P. not reached ◯ Call interrupted ◯ P. not willing	◯ no ◯ yes ▯ *if no,* why? _____	◯ no ◯ yes ▯ *if no,* why? _____	|__||__|:|__||__| Symptoms? ◯ no ◯ yes
06	|__||__|/|__||__|/|__||__| |__||__||__|	1.|__||__|:|__||__| 2.|__||__|:|__||__| 3.|__||__|:|__||__|	◯ P. reached ◯ P. not reached ◯ Call interrupted ◯ P. not willing	◯ no ◯ yes ▯ *if no,* why? _____	◯ no ◯ yes ▯ *if no,* why? _____	|__||__|:|__||__| Symptoms? ◯ no ◯ yes
07	|__||__|/|__||__|/|__||__| |__||__||__|	1.|__||__|:|__||__| 2.|__||__|:|__||__| 3.|__||__|:|__||__|	◯ P. reached ◯ P. not reached ◯ Call interrupted ◯ P. not willing	◯ no ◯ yes ▯ *if no,* why? _____	◯ no ◯ yes ▯ *if no,* why? _____	|__||__|:|__||__| Symptoms? ◯ no ◯ yes

C. Protocol of telephone interviews (continuation)

Day	Date and Interviewer initials	Time of calls	Outcome (after 3 trials)	Daily Interview done?	Medication Use updated?	End time
____	|__|__|/|__|__|/|__|__| |__|__|__|	1.|__|__|:|__|__| 2.|__|__|:|__|__| 3.|__|__|:|__|__|	◯ P. reached ◯ P. not reached ◯ Call interrupted ◯ P. not willing	◯ no ◯ yes ▯ *if no,* why? _____	◯ no ◯ yes ▯ *if no,* why? _____	|__|__|:|__|__| Symptoms? ◯ no ◯ yes
____	|__|__|/|__|__|/|__|__| |__|__|__|	1.|__|__|:|__|__| 2.|__|__|:|__|__| 3.|__|__|:|__|__|	◯ P. reached ◯ P. not reached ◯ Call interrupted ◯ P. not willing	◯ no ◯ yes ▯ *if no,* why? _____	◯ no ◯ yes ▯ *if no,* why? _____	|__|__|:|__|__| Symptoms? ◯ no ◯ yes
____	|__|__|/|__|__|/|__|__| |__|__|__|	1.|__|__|:|__|__| 2.|__|__|:|__|__| 3.|__|__|:|__|__|	◯ P. reached ◯ P. not reached ◯ Call interrupted ◯ P. not willing	◯ no ◯ yes ▯ *if no,* why? _____	◯ no ◯ yes ▯ *if no,* why? _____	|__|__|:|__|__| Symptoms? ◯ no ◯ yes
____	|__|__|/|__|__|/|__|__| |__|__|__|	1.|__|__|:|__|__| 2.|__|__|:|__|__| 3.|__|__|:|__|__|	◯ P. reached ◯ P. not reached ◯ Call interrupted ◯ P. not willing	◯ no ◯ yes ▯ *if no,* why? _____	◯ no ◯ yes ▯ *if no,* why? _____	|__|__|:|__|__| Symptoms? ◯ no ◯ yes
____	|__|__|/|__|__|/|__|__| |__|__|__|	1.|__|__|:|__|__| 2.|__|__|:|__|__| 3.|__|__|:|__|__|	◯ P. reached ◯ P. not reached ◯ Call interrupted ◯ P. not willing	◯ no ◯ yes ▯ *if no,* why? _____	◯ no ◯ yes ▯ *if no,* why? _____	|__|__|:|__|__| Symptoms? ◯ no ◯ yes
____	|__|__|/|__|__|/|__|__| |__|__|__|	1.|__|__|:|__|__| 2.|__|__|:|__|__| 3.|__|__|:|__|__|	◯ P. reached ◯ P. not reached ◯ Call interrupted ◯ P. not willing	◯ no ◯ yes ▯ *if no,* why? _____	◯ no ◯ yes ▯ *if no,* why? _____	|__|__|:|__|__| Symptoms? ◯ no ◯ yes
____	|__|__|/|__|__|/|__|__| |__|__|__|	1.|__|__|:|__|__| 2.|__|__|:|__|__| 3.|__|__|:|__|__|	◯ P. reached ◯ P. not reached ◯ Call interrupted ◯ P. not willing	◯ no ◯ yes ▯ *if no,* why? _____	◯ no ◯ yes ▯ *if no,* why? _____	|__|__|:|__|__| Symptoms? ◯ no ◯ yes
____	|__|__|/|__|__|/|__|__| |__|__|__|	1.|__|__|:|__|__| 2.|__|__|:|__|__| 3.|__|__|:|__|__|	◯ P. reached ◯ P. not reached ◯ Call interrupted ◯ P. not willing	◯ no ◯ yes ▯ *if no,* why? _____	◯ no ◯ yes ▯ *if no,* why? _____	|__|__|:|__|__| Symptoms? ◯ no ◯ yes
____	|__|__|/|__|__|/|__|__| |__|__|__|	1.|__|__|:|__|__| 2.|__|__|:|__|__| 3.|__|__|:|__|__|	◯ P. reached ◯ P. not reached ◯ Call interrupted ◯ P. not willing	◯ no ◯ yes ▯ *if no,* why? _____	◯ no ◯ yes ▯ *if no,* why? _____	|__|__|:|__|__| Symptoms? ◯ no ◯ yes
____	|__|__|/|__|__|/|__|__| |__|__|__|	1.|__|__|:|__|__| 2.|__|__|:|__|__| 3.|__|__|:|__|__|	◯ P. reached ◯ P. not reached ◯ Call interrupted ◯ P. not willing	◯ no ◯ yes ▯ *if no,* why? _____	◯ no ◯ yes ▯ *if no,* why? _____	|__|__|:|__|__| Symptoms? ◯ no ◯ yes
____	|__|__|/|__|__|/|__|__| |__|__|__|	1.|__|__|:|__|__| 2.|__|__|:|__|__| 3.|__|__|:|__|__|	◯ P. reached ◯ P. not reached ◯ Call interrupted ◯ P. not willing	◯ no ◯ yes ▯ *if no,* why? _____	◯ no ◯ yes ▯ *if no,* why? _____	|__|__|:|__|__| Symptoms? ◯ no ◯ yes
____	|__|__|/|__|__|/|__|__| |__|__|__|	1.|__|__|:|__|__| 2.|__|__|:|__|__| 3.|__|__|:|__|__|	◯ P. reached ◯ P. not reached ◯ Call interrupted ◯ P. not willing	◯ no ◯ yes ▯ *if no,* why? _____	◯ no ◯ yes ▯ *if no,* why? _____	|__|__|:|__|__| Symptoms? ◯ no ◯ yes

Sisters Hospitallers / KCCR / BNITM	Page 1	☐ multiple choice ○ single choice |__| alphanumeric *Grey sections to be completed by study nurse*	**CLEAR** **Case Report Form – Hospitalization** **St. Francis Xavier Hospital**	Visit Bar Code

A. Identification

A01	**Hospital-ID** |__||__||__||__||__||__| / |__||__|	**Screening ID:**
A02	Age |__||__| years	
A03	Sex ○ male ○ female	
A04	Community_____	
A05	Date of interview |__||__| / |__||__| / |__||__| (dd/mm/yy)	
A06	Is the patient participating in another study? ○ no ○ yes → *if yes*, which? _____	

B. Admission

B01	Date of admission |__||__| / |__||__| / |__||__| (dd/mm/yy)
B02	Has the patient been referred by another hospital? ○ no ○ yes → *if yes*, hospitalized for more than two days? ○ no ○ yes
B03	Ward _____

C. Pregnancy *[only if the women is/was pregnant]*

C01	Assessment date |__||__| / |__||__| / |__||__| (dd/mm/yy)
C02	Are there any complications? ○ no ○ yes → *if yes*, which? _____
C03	Outcome at discharge: ○ Still pregnant ○ Birth (regular) ○ Preterm birth ○ Stillbirth ○ Abort ○ Unknown
C04	→ *if pregnancy was terminated,* Date|__||__| / |__||__| / |__||__| (dd/mm/yy)
C05	→ *if baby delivered,* Is the mother breastfeeding? ○ no ○ yes

D. Clinical management during hospital stay – Oxygen Therapy

D01	Did the patient receive oxygen therapy during hospitalization? ○ no ○ yes ○ unknown
D01	→*if yes*, Did the patient receive invasive ventilation? ○ no ○ yes ○ unknown Did the patient receive non-invasive ventilation (e.g CPAP / BIPAP) ? ○ no ○ yes ○ unknown
D01	→*if yes (non-invasive ventilation)*, please specify: Source of oxygen: ○Piped ○Cylinder ○Concentrator ○Unknown Interface: ○Nasal prongs ○HF nasal cannula ○Mask ○Mask with reservoir ○CPAP/NIV mask ○unknown Inotropes/vasopressors? ○ no ○ yes ○ unknown

	Renal replacement therapy (RRT) or dialysis? ○ no ○ yes ○ unknown

D. Clinical management during hospital stay – Antibiotic therapy

D02	**Antibiotic received?** ○ no ○ yes ○ unknown → *if yes, please specify:*	
	Please tick	**Start date** (dd/mm/yy) - **End date** (dd/mm/yy)
☐	Macrolides (e.g. Azithromycin, Clarithromycin)	|__||__|/|__||__|/|__||__| - |__||__|/|__||__|/|__||__| ○ ongoing
☐	Fluoroquinolones (e.g. ciprofloxacin, levofloxacin)	|__||__|/|__||__|/|__||__| - |__||__|/|__||__|/|__||__| ○ ongoing
☐	3rd and 4th generation Cephalosporins (e.g. ceftriaxone, defotaxime, ceftazidime, cefepime)	|__||__|/|__||__|/|__||__| - |__||__|/|__||__|/|__||__| ○ ongoing
☐	Carbapenems (e.g. imipenem, meropenem)	|__||__|/|__||__|/|__||__| - |__||__|/|__||__|/|__||__| ○ ongoing
☐	Piperacillin + Tazobactam	|__||__|/|__||__|/|__||__| - |__||__|/|__||__|/|__||__| ○ ongoing
☐	Amoxicillin-clavulanate	|__||__|/|__||__|/|__||__| - |__||__|/|__||__|/|__||__| ○ ongoing
☐	Ampicilin	|__||__|/|__||__|/|__||__| - |__||__|/|__||__|/|__||__| ○ ongoing
☐	Cotrimoxazole	|__||__|/|__||__|/|__||__| - |__||__|/|__||__|/|__||__| ○ ongoing
☐	Other antibiotics:	
	1.)	|__||__|/|__||__|/|__||__| - |__||__|/|__||__|/|__||__| ○ ongoing
	2.)	|__||__|/|__||__|/|__||__| - |__||__|/|__||__|/|__||__| ○ ongoing
	3.)	|__||__|/|__||__|/|__||__| - |__||__|/|__||__|/|__||__| ○ ongoing

☐ multiple choice
○ single choice
|__| alphanumeric
Grey sections to be completed by study nurse

CLEAR
Case Report Form – Hospitalization
St. Francis Xavier Hospital

Visit Bar Code

D. Clinical management during hospital stay – Other drugs I

D03
Antithrombotic/anticoagulation drugs received? ○ no ○ yes ○ unknown
→ *if yes*, specify:
☐ Unfractionated heparin
☐ Low molecular weight heparin
☐ Warfarin
☐ Direct oral anticoagulant
☐ Other: _____
Dose: ○ Preventive dose ○ Therapeutic dose

D04
Antiviral drugs received? ○ no ○ yes ○ unknown
→ *if yes*, specify:
☐ Lopinavir/Ritonavir
☐ Darunavir +/- cobiscistat
☐ Remdesivir
☐ Favipiravir
☐ Acyclovir/Ganciclovir
☐ Oseltamivir
☐ Nirmatrelvir
☐ Other: _____

D05
Antifungal agent received? ○ no ○ yes ○ unknown
→ *if yes*, specify:
_____
Non-Steroidal anti-inflammatory (NSAID) received? ○ no ○ yes ○ unknown
→ *if yes*, specify:
_____

D06
Blood derived products received? ○ no ○ yes ○ unknown
→ *if yes*, specify:
☐ IV immune globulin
☐ Convalescent plasma
☐ Other: _____

D. Clinical management during hospital stay – Other drugs II

D07
Experimental agents received? ○ no ○ yes ○ unknown
→ *if yes*, specify:
☐ Ivermectin
☐ Ciclesonide
☐ Nitazoxanide
☐ ASAQ
☐ Fluoxetine
☐ Budesonide
☐ Other agent: _____

D08
Steroids received? ○ no ○ yes ○ unknown
→ *if yes*, specify:
☐ Dexamethasone
☐ Hydrocortisone
☐ Prednisone
☐ Methylprednisolone
☐ Other: _____
Duration of steroid therapy: |__||__| days

D09
Other drugs received? ○ no ○ yes ○ unknown
→if yes, specify:
1.)_____
2.)_____
3.)_____

E. Diagnostics

E01
Rx Thorax
Was the assessment completed? ○ no ○ yes
Assessment date (dd/mm/yy) |__||__| / |__||__| / |__||__|
Result assessable ○ normal ○ abnormal ○ not
→ *if abnormal,* relation to COVID-19 ○ related ○ not related ○ unknown
Clinical significant? ○ no ○ yes
Remarks: _____

☐ multiple choice
◯ single choice
|__| alphanumeric
Grey sections to be completed by study nurse

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F. Laboratory analyses

F01	Which of the following laboratory analysis were conducted? ▯ WBC/FBC ▯ Urine
F02	Were sample(s) sent to the lab for culture (Tick if yes and add number) ▯ Blood Number: |__||__| ▯ Urine Number: |__||__| ▯ Cerebrospinal fluid Number: |__||__| ▯ Wound Number: |__||__| ▯ BAL (protected resp. specimen) Number: |__||__| ▯ Sputum/bronchial aspirate Number: |__||__| ▯ Other type of specimen If yes, specify: _____
F03	Were results of the antibiotic susceptibility testing made available? ◯ Yes ◯ No
F04	If yes, on which day? |__||__| / |__||__| / |__||__| (dd/mm/yy)

G. Discharge

G01	Date of hospital discharge: |__||__| / |__||__| / |__||__| (dd/mm/yy)
G02	Duration of hospital stay (total): |__||__||__|days
G03	Outcome: ◯ fully recovered without ongoing treatment ◯ discharged with ongoing treatment ◯ discharged with permanent disability/treatment ◯ referred to another hospital ◯ died ◯ still hospitalized, but case was closed ◯ absconded/lost to follow-up
G04	**Diagnoses on discharge** 1st Diagnosis: _____ 2nd Diagnosis: _____ 3rd Diagnosis: _____
G05	Does the patient have confirmed malaria? ◯ no ◯ yes ◯ unknown → *if yes*, is it severe malaria? ◯ no ◯ yes ◯ unknown Does the patient have confirmed bacterial sepsis? ◯ no ◯ yes ◯ unknown

H. Remarks

_____

_____

_____

I. Responsibilities

Study nurse who filled in the questionnaire:

Initials |__||__||__| Date |__||__|/|__||__|/|__||__| (dd/mm/yy)

Doctor who filled in the questionnaire:

Initials |__||__||__| Date |__||__|/|__||__|/|__||__| (dd/mm/yy)

Study nurse/ staff who performed the bedside tests:

Initials |__||__||__| Date |__||__|/|__||__|/|__||__| (dd/mm/yy)

Study Doctor who checked the questionnaire:

Initials |__||__||__| Date |__||__|/|__||__|/|__||__| (dd/mm/yy)

Data staff who entered the data in the database:

Initials |__||__||__| Date |__||__|/|__||__|/|__||__| (dd/mm/yy)

Data staff who reviewed the data entry:

Initials |__||__||__| Date |__||__|/|__||__|/|__||__| (dd/mm/yy)