

CASE RECORD FORM INSTRUCTIONS

SEVERE ACUTE RESPIRATORY INFECTION CLINICAL CHARACTERISATION DATA TOOLS

DESIGN OF THIS CASE RECORD FORM (CRF)

This CRF is divided into 4 main forms: a “RAPID” (page 1) form with basic admission and outcome data; a “CORE” form with more detailed presentation (pages 2-3) and outcome (pages 4-6) data; a “DAILY” form (page 7) for daily laboratory and clinical data; and a set of “SUPPLEMENTARY” (Page 8-14) forms for overflow data, study-specific inclusion criteria and other investigations. These forms should be used in one of the defined combinations below according to the site’s resource availability and scientific interests.

HOW TO USE THIS CRF

Each site may choose the amount of data to collect based on available resources and the number of patients enrolled to date. Ideally, data on patients presenting early in an outbreak will be collected using the Tier 2 schedule of forms outlined below. The decision is up to the site Investigators and may be changed throughout the data collection period. All high quality data is valuable for analysis.

Tier 0 – Complete the RAPID CRF only – For low resource sites or, during an epidemic, sites that have already enrolled large numbers of patients on the Tier 1/2 schedule.

Tier 1 – Complete the CORE CRF + complete the DAILY CRF on the first day of hospital admission and the first day of ICU admission (note: this could be the same day) – For sites that do not have the resources to collect the level of daily data in Tier 2.

Tier 2 - Complete the CORE CRF + complete the DAILY CRF on the first 2 days of hospital admission and the first 2 days of all ICU admissions. – For sites with available resources.

Additional CRF modules are available (e.g. study-specific inclusion criteria, epidemiology) to be completed in addition to any of the Tiers above according to the objectives of the site. If you would like access to additional CRFs, or to suggest a new module for inclusion in these forms please contact us at the email below.

GENERAL GUIDANCE

- The CRF is designed to collect data obtained through examination, interview and review of hospital notes. Data may be collected retrospectively if the patient is enrolled after the admission date.
- Participant Identification Numbers consist of a 3-digit network code, a 3 digit site code and a 4 digit participant number. You can obtain a network code and site code by registering on the data management system at www.cliresdms.org by contacting isaric@oucru.org. Participant numbers should be assigned sequentially for each site beginning with 0001. In the case of a single site recruiting participants on different wards, or where it is otherwise difficult to assign sequential numbers, it is acceptable to assign numbers in blocks or incorporating alpha characters. E.g. Ward X will assign numbers from 0001 or A001 onwards and Ward Y will assign numbers from 5001 or B001 onwards. Enter the Participant Identification Number at the top of every page.
- Data may be entered to the central database at www.cliresdms.org or to your site/network’s independent database.
- In the case of a participant transferring between study sites, it is preferred to maintain the same Participant Identification Number across the sites. When this is not possible, space for recording the new number is provided.
- Complete every line of every section, except for where the instructions say to skip a section based on certain responses.
- Selections with square boxes () are single selection answers (choose one answer only). Selections with circles () are multiple selection answers (choose as many answers as are applicable).
- Mark ‘N/A’ for any results that are not available, not applicable or unknown. For laboratory values, enter ‘N/A’ in the data space when results are not available, not applicable or unknown.
- Avoid recording data outside of the dedicated areas. Sections are available for recording additional information.
- We recommend writing clearly in ink, using BLOCK-CAPITAL LETTERS.
- Place an (X) when you choose the corresponding answer. To make corrections, strike through (-----) the data you wish to delete and write the correct data above it. Please initial and date all corrections.
- Please keep all of the sheets for a single participant together e.g. with a staple or participant-unique folder.
- Please enter data on the electronic data capture system at www.cliresdms.org. If your site would like to collect data independently, we are happy to support the establishment of locally hosted databases.
- Please contact us at isaric@oucru.org if we can help with databases, if you have comments and to let us know that you are using the forms.

RAPID CASE RECORD FORM - Severe Acute Respiratory Infection



PARTICIPANT IDENTIFICATION #: [][][][]- [][][][][]

This is the RAPID clinical data form for use in Tier 0 data collection only. Complete sections 1-3 at admission. Complete section 4 for ICU admission (if applicable). Complete sections 5&6 after discharge/death/transfer. Enter data to the database at www.cliresdms.org

1. SITE

Clinical centre name: _____ Country: _____

Enrolment date: [_] [_] / [_] [_] / [2] [0] [_] [_]

2. DEMOGRAPHICS

Sex at Birth: Male Female

Birth date: [_] [_] / [_] [_] / [_] [_] [_] [_]

If birth date unknown: Estimated age [] [] years OR [] [] months

Pregnant? YES NO Unknown N/A If YES: Gestational weeks assessment: [] [] weeks

3. ONSET & ADMISSION

Symptom onset date of first/earliest symptom: [_] [_] / [_] [_] / [2] [0] [_] [_]

Admission date at this facility: [_] [_] / [_] [_] / [2] [0] [_] [_]

4. INTENSIVE CARE OR HIGH DEPENDENCY CARE UNIT ADMISSION

ICU admission (or high dependency unit)? YES (complete the rest of this section) NO (skip this section)

First ICU admission date: [_] [_] / [_] [_] / [2] [0] [_] [_]

Record the worst value in first 24 hours of first ICU admission:

Mechanical ventilation YES NO N/A

FiO₂ (0.21-1.0) [] [] or [] [] L/min

SaO₂ at time of FiO₂ [] [] [] %

PaO₂ at time of FiO₂ [] [] [] kPa or mmHg

Platelet Count [] [] [] x10⁹/L

Mean arterial pressure [] [] [] mmHg

Glasgow Coma Score (GCS / 15): [] []

Urine flow rate [] [] [] mL/24 hours - Check if estimated

Record the highest value in first 24 hours of first ICU admission:

Total Bilirubin [] [] [] μmol/L

Creatinine [] [] [] μmol/L or mg/dL

Vasopressor/inotropic support on 1st day of ICU admission? YES NO (if NO, answer the next 3 questions NO) N/A

Dopamine <5μg/kg/min OR Dobutamine OR Milrinone OR Levosimendan:

YES NO

Dopamine 5-15μg/kg/min OR Epinephrine/Norepinephrine ≤0.1μg/kg/min OR vasopressin OR phenylephrine:

YES NO

Dopamine >15μg/kg/min OR Epinephrine/Norepinephrine >0.1μg/kg/min:

YES NO

Most recent ICU discharge date: [_] [_] / [_] [_] / [2] [0] [_] [_]

Total ICU duration: [] [] [] days

5. INFECTIOUS RESPIRATORY DIAGNOSIS

Influenza : YES- Confirmed YES- Probable NO If YES: A/H3N2 A/H1N1pdm09 A/H7N9 A/H5N1 B
 Other: _____

Coronavirus: YES- Confirmed YES- Probable NO If YES: MERS-CoV other: _____

Other: YES- Confirmed YES- Probable NO If YES: other: _____

Clinical pneumonia: YES NO If NONE OF THE ABOVE: Unknown/Non-infective: YES

6. OUTCOME

During hospital admission did the patient at any time receive:

Oxygen therapy: YES NO N/A Invasive ventilation YES NO N/A Non-invasive ventilation: YES NO N/A

ECMO/ECLS: YES NO N/A Dialysis: YES NO N/A Multiple ICU admissions: YES NO N/A

Outcome: Alive at discharge Hospitalization Transfer to other facility Death Palliative discharge N/A

CORE CASE RECORD FORM - Severe Acute Respiratory Infection



PARTICIPANT IDENTIFICATION #: [][][][]- [][][][][]

Outcome date: [D][D]/[M][M]/[2][0][Y][Y]

This is the CORE Data Form for use in Tier 1 and Tier 2 data collection. Complete CORE PRESENTATION sections 1-3 at admission. Enter data at www.cliresdms.org

1. DEMOGRAPHICS

Clinical centre name: _____ Country: _____

Enrolment date: [D][D]/[M][M]/[2][0][Y][Y]

Sex at Birth: Male Female Birth date: [D][D]/[M][M]/[Y][Y][Y][Y]

If birth date unknown: Estimated age [][][] years OR [][][] months

Pregnant? YES NO Unknown N/A If YES: Gestational weeks assessment: [][][] weeks N/A

Admission weight (whole number) [][][] kg or [][][] lbs N/A Height: [][][] cm or [][][] inches N/A

If age <5 years: Mid-upper-arm circumference [][][] mm N/A

Ethnic group (check all that apply): Arab Black East Asian South Asian West Asian Latin American
 White Aboriginal/First Nations Other: _____ N/A

Admission date at this facility: [D][D]/[M][M]/[2][0][Y][Y]

Transfer from other facility? YES-facility is a study site YES-facility is not a study site NO N/A

If YES: Name of transfer facility: _____ N/A

If YES: Admission date at transfer facility (DD/MM/YYYY): [D][D]/[M][M]/[2][0][Y][Y] N/A

If YES-Study Site: Participant # at transfer facility: Same as above Different: [][][][]- [][][][][] N/A

Travel in the 14 days prior to first symptom onset? YES NO N/A

If YES, state location(s) & date(s): Country: _____ City/Geographic area: _____

Return Date: [D][D]/[M][M]/[2][0][Y][Y] N/A (more space on SUPPLEMENTARY DATA FORM)

Contact with animals, raw meat or insect bites in the 14 days prior to symptom onset?

YES NO N/A If YES, complete the ANIMAL EXPOSURE section (see SUPPLEMENTARY DATA FORM).

2. CO-MORBIDITIES & RISK FACTORS (existing PRIOR TO ADMISSION & that are active problems)

Chronic cardiac disease (not hypertension)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Metastatic solid tumour	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Chronic pulmonary disease (not asthma)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Malignant neoplasm (including leukaemia & lymphoma)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Asthma (physician diagnosed)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	AIDS / HIV	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Chronic kidney disease	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Obesity (as defined by clinical staff)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Moderate or severe liver disease	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Diabetes with complications	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Mild liver disease	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Rheumatologic disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Chronic neurological disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Dementia	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Hemiplegia / Paraplegia	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A		

CORE CASE RECORD FORM - Severe Acute Respiratory Infection



PARTICIPANT IDENTIFICATION #: [][][][]- [][][][][]

2. CO-MORBIDITIES & RISK FACTORS... continued

Recurrent fever prior to admission? Yes No N/A

Malaria diagnosis after symptom onset? YES NO N/A

Treated with immunosuppressants, including oral (not inhaled) corticosteroids prior to admission? YES NO N/A
If YES, complete the ADMISSION IMMUNOSUPPRESSANTS section of the SUPPLEMENTARY DATA FORM.

Treatment with anti-infectives for this illness episode prior to admission? YES NO N/A
If YES, complete the ADMISSION ANTI-INFECTIVES section of the SUPPLEMENTARY DATA FORM.

POST PARTUM? YES NO or N/A (skip this section - go to INFANT)

Pregnancy Outcome: Live birth Still birth Delivery date: [_] [_] / [_] [_] / [2] [0] [_] [_]

Baby tested for Mom's infection? YES NO N/A If YES: Positive Negative Method: PCR Other: _____

INFANT – Less than 1 year old? YES NO (skip this section) Birth weight: [_] [_] . [_] kg or [_] lbs N/A

Gestational outcome: Term birth (≥37wk GA) Preterm birth (<37wk GA) N/A

Breastfed? YES NO N/A If YES: Currently breastfed Breastfeeding discontinued at [_] [_] weeks N/A

Appropriate development for age? YES NO N/A Vaccinations appropriate for age/country? YES NO N/A

Other relevant risk factor(s): _____

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

Symptom onset date (first/earliest symptom): [_] [_] / [_] [_] / [2] [0] [_] [_]

Temperature: [_] [_] [_] . [_] °C or °F HR: [_] [_] [_] beats per minute RR: [_] [_] breaths per minute

Systolic BP: [_] [_] [_] mmHg Diastolic BP: [_] [_] [_] mmHg

Severe dehydration? YES NO N/A Sternal capillary refill time >2 seconds? YES NO N/A

Oxygen saturation: [_] [_] [_]% On: Room air Oxygen therapy N/A

Admission signs and symptoms (observed/reported at admission and associated with this episode of acute illness)

History of fever	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Lower chest wall indrawing	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Cough	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Headache	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
with sputum production	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Altered consciousness/confusion	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
bloody sputum/haemoptysis	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Seizures	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Sore throat	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Abdominal pain	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Runny nose (Rhinorrhoea)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Vomiting / Nausea	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Ear pain	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Diarrhoea	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Wheezing	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Conjunctivitis	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Chest pain	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Skin rash	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Muscle aches (Myalgia)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Skin ulcers	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Joint pain (Arthralgia)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Lymphadenopathy	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Fatigue / Malaise	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Bleeding (Haemorrhage)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Shortness of breath (Dyspnea)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	If Bleeding: specify site(s): _____	

CORE CASE RECORD FORM - Severe Acute Respiratory Infection



PARTICIPANT IDENTIFICATION #: [][][]-[][][][][]

This is the CORE Data Form for use in Tier 1 and Tier 2 data collection. Complete CORE OUTCOME sections 4-8 after discharge/death/transfer.

4. COMPLICATIONS: At any time during hospitalisation did the patient experience:

Viral pneumonitis	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Cardiac arrest	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Bacterial pneumonia	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Bacteraemia	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Acute lung injury / Acute Respiratory Distress Syndrome	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Coagulation disorder / Disseminated Intravascular Coagulation	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Pneumothorax	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Anaemia	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Pleural effusion	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Rhabdomyolysis / Myositis	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Bronchiolitis	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Acute renal injury/ Acute renal failure	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Meningitis / Encephalitis	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Gastrointestinal haemorrhage	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Seizure	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Pancreatitis	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Stroke / Cerebrovascular accident	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Liver dysfunction	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Congestive heart failure	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Hyperglycemia	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Endocarditis / Myocarditis / Pericarditis	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Hypoglycemia	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Cardiac arrhythmia	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Other	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Cardiac ischaemia	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	<i>Specify:</i> _____	

5. PATHOGEN TESTING: Was pathogen testing done during this illness episode? YES (complete section) NO N/A

Collection Date (DD/MM/YYYY)	Biospecimen Type	Laboratory Test Method	Result	Pathogen Tested/Detected
___/___/20__	<input type="checkbox"/> Nasal/NP swab <input type="checkbox"/> Throat swab <input type="checkbox"/> Combined nasal/NP+throat swab <input type="checkbox"/> Sputum <input type="checkbox"/> BAL <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> Feces/rectal swab <input type="checkbox"/> Blood <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> PCR <input type="checkbox"/> Culture <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> N/A	_____
___/___/20__	<input type="checkbox"/> Nasal/NP swab <input type="checkbox"/> Throat swab <input type="checkbox"/> Combined nasal/NP+throat swab <input type="checkbox"/> Sputum <input type="checkbox"/> BAL <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> Feces/rectal swab <input type="checkbox"/> Blood <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> PCR <input type="checkbox"/> Culture <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> N/A	_____
___/___/20__	<input type="checkbox"/> Nasal/NP swab <input type="checkbox"/> Throat swab <input type="checkbox"/> Combined nasal/NP+throat swab <input type="checkbox"/> Sputum <input type="checkbox"/> BAL <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> Feces/rectal swab <input type="checkbox"/> Blood <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> PCR <input type="checkbox"/> Culture <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> N/A	_____
___/___/20__	<input type="checkbox"/> Nasal/NP swab <input type="checkbox"/> Throat swab <input type="checkbox"/> Combined nasal/NP+throat swab <input type="checkbox"/> Sputum <input type="checkbox"/> BAL <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> Feces/rectal swab <input type="checkbox"/> Blood <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> PCR <input type="checkbox"/> Culture <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> N/A	_____
___/___/20__	<input type="checkbox"/> Nasal/NP swab <input type="checkbox"/> Throat swab <input type="checkbox"/> Combined nasal/NP+throat swab <input type="checkbox"/> Sputum <input type="checkbox"/> BAL <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> Feces/rectal swab <input type="checkbox"/> Blood <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> PCR <input type="checkbox"/> Culture <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> N/A	_____

CORE CASE RECORD FORM - Severe Acute Respiratory Infection



PARTICIPANT IDENTIFICATION #: [][][]-[][][][][]

6. TREATMENT: At ANY time during hospitalisation, did the patient receive/undergo:

ICU or High Dependency Unit admission? YES NO N/A..... If YES, total number of ICU/HDU admissions: _____

If YES: First admission date: [D][D]/[M][M]/[2][0][Y][Y] N/A If YES, total duration: _____ days

Most recent discharge date: [D][D]/[M][M]/[2][0][Y][Y] N/A

Oxygen therapy? YES NO N/A If YES, total duration: _____ days

If YES: First/Start date: [D][D]/[M][M]/[2][0][Y][Y] N/A

Last/End date: [D][D]/[M][M]/[2][0][Y][Y] N/A

Non-invasive ventilation? (e.g. BIPAP, CPAP) YES NO N/A..... If YES, total duration: _____ days

Invasive ventilation (Any)? YES NO N/A..... If YES, total duration: _____ days

If YES: First/Start date: [D][D]/[M][M]/[2][0][Y][Y] N/A

Last/End date: [D][D]/[M][M]/[2][0][Y][Y] N/A

Oscillatory Ventilation? YES NO N/A If YES, total duration: _____ days

Prone Ventilation? YES NO N/A If YES, total duration: _____ days

Inhaled Nitric Oxide? YES NO N/A If YES, total duration: _____ days

Extracorporeal membrane oxygenation (ECMO) or interventional lung-assist therapy (iLA)?

ECMO iLA None Not available at site N/A If YES, total duration: _____ days

If YES: First/Start date: [D][D]/[M][M]/[2][0][Y][Y] N/A

Last/End date: [D][D]/[M][M]/[2][0][Y][Y] N/A

Renal replacement therapy (RRT) or dialysis? YES NO N/A..... If YES, total duration: _____ days

If YES: First/Start date: [D][D]/[M][M]/[2][0][Y][Y] N/A

Last/End date: [D][D]/[M][M]/[2][0][Y][Y] N/A

Inotropes/vasopressors? YES NO N/A If YES, total duration: _____ days

If YES: First/Start date: [D][D]/[M][M]/[2][0][Y][Y] N/A

Last/End date: [D][D]/[M][M]/[2][0][Y][Y] N/A

Plasmapheresis/exchange? YES NO N/A **Oral rehydration therapy only?** YES NO N/A

Intravenous Immunoglobulin? YES NO N/A **Blood transfusion or products?** YES NO N/A

OTHER intervention or procedure (please specify): _____

7. MEDICATION: While hospitalised or at discharge, were any of the following administered?

Antiviral agent? YES NO N/A **If YES:** Neuraminidase Inhibitors Other **Antibiotic?** YES NO N/A

Corticosteroid? YES NO N/A **If YES, Route:** Oral Intravenous Inhaled **Antifungal agent?** YES NO N/A

If any of the anti-infectives or corticosteroids listed above were administered, please complete the MEDICATION: ANTI-INFECTIVES & CORTICOSTEROIDS section of the SUPPLEMENTAL DATA FORM.

Angiotensin converting enzyme inhibitors (ACE-Is) or angiotensin receptor blockers (ARBs)? YES NO N/A

Statins (HMG-CoA Reductase Inhibitor)? YES NO N/A **If YES: Taking statins prior to admission?** YES NO N/A

CORE CASE RECORD FORM - Severe Acute Respiratory Infection



PARTICIPANT IDENTIFICATION #: [][][]-[][][][][]

8. OUTCOME

Outcome: Alive at discharge Hospitalization Transfer to other facility Death Palliative discharge N/A

Outcome date: [D][D]/[M][M]/[2][0][Y][Y] N/A

If Discharged alive: Ability to self-care at discharge versus before illness: Same as before illness Worse Better N/A

If Discharged alive: Post-discharge treatment:

Oxygen therapy? YES NO N/A

Dialysis/renal treatment? YES NO N/A

Other intervention or procedure? YES NO N/A

If YES: Specify (multiple permitted): _____

If Transferred: Facility name: _____ N/A

If Transferred: Is the transfer facility a study site? YES NO N/A

If a Study Site: Participant # at new facility: Same as above Different: [][][]-[][][][][] N/A

If Died: Primary cause of death (one only):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Multi-organ dysfunction syndrome | <input type="checkbox"/> Acute lung injury | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Myocardial infarction |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Dysrhythmia | <input type="checkbox"/> Chronic obstructive lung disease | <input type="checkbox"/> Pulmonary emboli |
| <input type="checkbox"/> Cerebrovascular disease | <input type="checkbox"/> Renal failure | <input type="checkbox"/> Liver failure | <input type="checkbox"/> Malignant neoplasm |
| <input type="checkbox"/> Other, specify: _____ | | | <input type="checkbox"/> N/A |

If Died: Secondary cause(s) of death (check all that apply): N/A

- | | | | |
|--|---|--|---|
| <input type="radio"/> Multi-organ dysfunction syndrome | <input type="radio"/> Acute lung injury | <input type="radio"/> Pneumonia | <input type="radio"/> Myocardial infarction |
| <input type="radio"/> Congestive heart failure | <input type="radio"/> Dysrhythmia | <input type="radio"/> Chronic obstructive lung disease | <input type="radio"/> Pulmonary emboli |
| <input type="radio"/> Cerebrovascular disease | <input type="radio"/> Renal failure | <input type="radio"/> Liver failure | <input type="radio"/> Malignancy |
| <input type="radio"/> Other, specify: _____ | | <input type="radio"/> Other, specify: _____ | |

Diagnosis (check/complete all that apply):

Influenza: YES- Confirmed YES- Probable NO **If YES:** A/H3N2 A/H1N1pdm09 A/H7N9 A/H5N1 B
 Other: _____

Coronavirus: YES- Confirmed YES- Probable NO **If YES:** MERS-CoV Other: _____

Clinical pneumonia: YES NO

Other (1): YES- Confirmed YES- Probable NO **If YES:** Other: _____

Other (2): YES- Confirmed YES- Probable NO **If YES:** Other: _____

Other (3): YES- Confirmed YES- Probable NO **If YES:** Other: _____

If none of the above: Unknown/Non-infective: YES

DAILY CASE RECORD FORM - Severe Acute Respiratory Infection



PARTICIPANT IDENTIFICATION #: [][][][]- [][][][][]

Tier 1 - complete DAILY form on first day of hospital admission + first day of ICU/HDU admission. Tier 2 – Complete DAILY form on 1st & 2nd days of hospital admission; 1st & 2nd day of all ICU admissions; and any day that research samples are taken.

1. DATE OF ASSESSMENT (DD/MM/YYYY): [][][][]/[][][][]/[][][][][][] (may not be the date of completion)

2. DAILY TREATMENT (complete every line):

Current admission to ICU/ITU/IMC/HDU? YES NO N/A

Record the worst value in the previous 24 hours (if Not Available write 'N/A'):

FiO₂ (0.21-1.0) [][]/[][][] or [][][][]L/min

SaO₂ [][][][]%

PaO₂ at time of FiO₂ above [][][][] kPa or mmHg

PaO₂ sample type: Arterial Venous Capillary N/A

From same blood gas record as PaO₂ PCO₂ _____ kPa or mmHg

pH _____

HCO₃⁻ _____ mEq/L

Base excess _____ mmol/L

Glasgow Coma Score (GCS / 15) [][][]

Mean Arterial Blood Pressure [][][][][]mmHg

Urine flow rate [][][][][][]mL/24 hours Check if estimated

Is the patient currently receiving, or has received in the past 24 hours (apply to all questions in this section) :

Non-invasive ventilation (eg. BIPAP, CPAP)? YES NO N/A

Invasive ventilation? YES NO N/A

Oscillatory Ventilation? YES NO N/A

Extracorporeal membrane oxygenation (ECMO/ECLS)? YES NO N/A

Interventional lung-assist therapy (iLA)? YES NO N/A

Dialysis/Hemofiltration? YES NO N/A

Any vasopressor/inotropic support? YES NO (if NO, answer the next 3 questions NO) N/A

Dopamine <5µg/kg/min OR Dobutamine OR milrinone OR levosimendan:

YES NO

Dopamine 5-15µg/kg/min OR Epinephrine/Norepinephrine < 0.1µg/kg/min OR vasopressin OR phenylephrine:

YES NO

Dopamine >15µg/kg/min OR Epinephrine/Norepinephrine > 0.1µg/kg/min:

YES NO

Oral rehydration only? YES NO N/A

Intravenous Immunoglobulin? YES NO N/A

Blood transfusion or products? YES NO N/A

Plasmapheresis/Exchange? YES NO N/A

Other intervention or procedure: YES NO N/A If YES, Specify: _____

3. DAILY LABORATORY RESULTS

Results available for samples taken on the date in section 1 above? YES (complete below) NO (skip section)

Haemoglobin _____ g/L or g/dL

Haematocrit _____ %

WBC count _____ x10⁹/L or x10³/µL

Platelets _____ x10⁹/L or x10³/µL

APTT/APTR _____

PT _____ seconds or INR _____

ALT/SGPT _____ U/L

Total Bilirubin _____ µmol/L or mg/dL

C-reactive protein _____ mg/L or

nmol/L

AST/SGOT _____ U/L

Glucose _____ mmol/L or mg/dL

Erythrocyte Sed Rate _____ mm/h

Blood Urea Nitrogen (urea) _____ mmol/L or mg/dL

Lactate _____ mmol/L or mg/dL

LDH _____ U/L

Creatine kinase CPK _____ U/L

Creatinine _____ µmol/L or mg/dL

4. CHEST X-RAY

Are results available for a chest x-ray performed on the date in section 1 above? YES (complete below) NO (skip section)

Are infiltrates present? YES NO N/A

If YES:

Check all quadrants where infiltrates are present: Right upper Right lower Left upper Left lower N/A

SUPPLEMENTARY to CORE CASE RECORD FORM - Severe Acute Respiratory Infection



PARTICIPANT IDENTIFICATION #: [][][]- [][][][]

EXTRA SPACE FOR INFORMATION ON THE CORE DATA FORM

Use this form to record information that does not fit the space provided in the CASE REPORT FORM or where detailed. All information from the CASE REPORT FORM and this SUPPLEMENTARY DATA FORM should be entered into the appropriate sections of the electronic CASE REPORT FORM at <https://www.cliresdms.org>

CORE - SECTION 1 - TRAVEL: Did the patient travel in the 14 days prior to first symptom onset? If > 1 location & date list:

Country: _____ City/Geographic area: _____ Return Date (DD/MM/20YY): ____ / ____ /20____

Country: _____ City/Geographic area: _____ Return Date (DD/MM/20YY): ____ / ____ /20____

Country: _____ City/Geographic area: _____ Return Date (DD/MM/20YY): ____ / ____ /20____

CORE - SECTION 1 – ANIMAL EXPOSURES: Did the patient have contact with live/dead animals, raw meat or insect bites in the 14 days prior to first symptom onset? Complete each line below.

If YES, specify the animal/insect, type of contact and date of exposure (DD/MM/YYYY) here:

Bird/Aves (e.g. chickens, turkeys, ducks)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Bat	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Livestock (e.g. goats, cattle, camels)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Horse	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Hare/ Rabbit	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Pigs	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Non-human primates	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Rodent (e.g. rats, mice, squirrels)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Insect bite (e.g. tick, flea, mosquito)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Reptile / Amphibian	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Domestic animals living in his/her home (e.g. cats, dogs, other)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Animal feces or nests	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Sick animal or dead animal	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Raw animal meat / animal blood	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Skinned, dressed or eaten wild game	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Visit to live animal market, farm or zoo	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Participated in animal surgery or necropsy	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Other animal contacts:	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	

SUPPLEMENTARY to CORE CASE RECORD FORM - Severe Acute Respiratory Infection



PARTICIPANT IDENTIFICATION #: [][][]-[][][][][]

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CORE - SECTION 2 – ADMISSION IMMUNOSUPPRESSANT: Receiving immunosuppressants (including inhaled/oral corticosteroids) prior to admission? Enter the details below.			
Name of immunosuppressant	Dose and frequency	Route of administration	Duration
	<input type="checkbox"/> unknown	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A	<input type="checkbox"/> days <input type="checkbox"/> weeks <input type="checkbox"/> N/A
	<input type="checkbox"/> unknown	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A	<input type="checkbox"/> days <input type="checkbox"/> weeks <input type="checkbox"/> N/A
	<input type="checkbox"/> unknown	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A	<input type="checkbox"/> days <input type="checkbox"/> weeks <input type="checkbox"/> N/A
	<input type="checkbox"/> unknown	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A	<input type="checkbox"/> days <input type="checkbox"/> weeks <input type="checkbox"/> N/A
	<input type="checkbox"/> unknown	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A	<input type="checkbox"/> days <input type="checkbox"/> weeks <input type="checkbox"/> N/A

CORE - SECTION 2 – ADMISSION ANTI-INFECTIVES: Treated with anti-infectives (antibiotics and anti-virals) for this illness episode prior to admission? Enter details below.				
Name of medication (generic name preferred)	Dose and frequency	Start date (DD/MM/20YY)	End date (DD/MM/20YY)	Route of administration
	<input type="checkbox"/> N/A	___/___/20__	<input type="checkbox"/> On-going ___/___/20__	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20__	<input type="checkbox"/> On-going ___/___/20__	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20__	<input type="checkbox"/> On-going ___/___/20__	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20__	<input type="checkbox"/> On-going ___/___/20__	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20__	<input type="checkbox"/> On-going ___/___/20__	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A

CORE – ADDITIONAL INFORMATION: Detail any additional information not captured in the CASE REPORT FORM.

SUPPLEMENTARY to CORE CASE RECORD FORM - Severe Acute Respiratory Infection



PARTICIPANT IDENTIFICATION #: [][][]-[][][][][]

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CORE - SECTION 5 –PATHOGEN TESTING: Results of pathogen testing done during this illness episode.				
Sample Collection Date (DD/MM/YYYY)	Biospecimen Type	Laboratory Test Method	Result	Pathogen
___/___/20__	<input type="checkbox"/> Nasal/NP swab <input type="checkbox"/> Throat swab <input type="checkbox"/> Combined nasal/NP+throat swab <input type="checkbox"/> Sputum <input type="checkbox"/> BAL <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> Feces/rectal swab <input type="checkbox"/> Blood <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> PCR <input type="checkbox"/> Culture <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> N/A	_____
___/___/20__	<input type="checkbox"/> Nasal/NP swab <input type="checkbox"/> Throat swab <input type="checkbox"/> Combined nasal/NP+throat swab <input type="checkbox"/> Sputum <input type="checkbox"/> BAL <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> Feces/rectal swab <input type="checkbox"/> Blood <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> PCR <input type="checkbox"/> Culture <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> N/A	_____
___/___/20__	<input type="checkbox"/> Nasal/NP swab <input type="checkbox"/> Throat swab <input type="checkbox"/> Combined nasal/NP+throat swab <input type="checkbox"/> Sputum <input type="checkbox"/> BAL <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> Feces/rectal swab <input type="checkbox"/> Blood <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> PCR <input type="checkbox"/> Culture <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> N/A	_____
___/___/20__	<input type="checkbox"/> Nasal/NP swab <input type="checkbox"/> Throat swab <input type="checkbox"/> Combined nasal/NP+throat swab <input type="checkbox"/> Sputum <input type="checkbox"/> BAL <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> Feces/rectal swab <input type="checkbox"/> Blood <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> PCR <input type="checkbox"/> Culture <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> N/A	_____
___/___/20__	<input type="checkbox"/> Nasal/NP swab <input type="checkbox"/> Throat swab <input type="checkbox"/> Combined nasal/NP+throat swab <input type="checkbox"/> Sputum <input type="checkbox"/> BAL <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> Feces/rectal swab <input type="checkbox"/> Blood <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> PCR <input type="checkbox"/> Culture <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> N/A	_____
___/___/20__	<input type="checkbox"/> Nasal/NP swab <input type="checkbox"/> Throat swab <input type="checkbox"/> Combined nasal/NP+throat swab <input type="checkbox"/> Sputum <input type="checkbox"/> BAL <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> Feces/rectal swab <input type="checkbox"/> Blood <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> PCR <input type="checkbox"/> Culture <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> N/A	_____
___/___/20__	<input type="checkbox"/> Nasal/NP swab <input type="checkbox"/> Throat swab <input type="checkbox"/> Combined nasal/NP+throat swab <input type="checkbox"/> Sputum <input type="checkbox"/> BAL <input type="checkbox"/> ETA <input type="checkbox"/> Urine <input type="checkbox"/> Feces/rectal swab <input type="checkbox"/> Blood <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> PCR <input type="checkbox"/> Culture <input type="checkbox"/> Other, <i>Specify:</i> _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> N/A	_____

SUPPLEMENTARY to CORE CASE RECORD FORM - Severe Acute Respiratory Infection



PARTICIPANT IDENTIFICATION #: [][][]- [][][][][]

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CORE - SECTION 7 – MEDICATION: ANTI-INFECTIVES & CORTICOSTEROIDS – List all anti-infectives and corticosteroids administered during hospitalisation and at discharge. Use as many pages as required.

Name of medication (generic name preferred)	Dose and frequency (specify or unknown)	Start date (DD/MM/20YY)	End date (DD/MM/20YY)	Route of administration
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A
	<input type="checkbox"/> N/A	___/___/20___	___/___/20___ <input type="checkbox"/> On-going	<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Inhaled <input type="checkbox"/> Other <input type="checkbox"/> N/A

SUPPLEMENTARY CASE RECORD FORM - Severe Acute Respiratory Infection



PARTICIPANT IDENTIFICATION #: [][][]-[][][][][]

ADDITIONAL EPIDEMIOLOGICAL INVESTIGATIONS (Tier 3)

Investigations additional to those on the CASE REPORT FORMs may be of interest to some sites. Some examples of relevant data are below and can be completed at the discretion of the site. All information should be entered into the appropriate sections of the electronic database at <https://www.cliresdms.org>

EXPOSURES IN THE PREVIOUS 14 DAYS:

Confirmed case contact? YES NO N/A
 Probable case contact? YES NO N/A
 Travel? YES NO N/A Animal? YES NO N/A Occupational? YES NO N/A

LIVING ARRANGEMENT: What was the primary living situation of the patient in the 14 days before presentation to hospital?

Home. # of people in home (including patient): _____
 Military base Correctional institution Shelter
 Boarding school/dormitory Nursing home/long-term healthcare facility
 Other: _____ N/A

OCCUPATION: What is the patient's occupation? _____ N/A

VACCINATION HISTORY:

Influenza immunization this season? YES this season YES-this year, but no clear season NO N/A
 If YES: ≥14 days prior to illness <14 days prior to illness
 If YES: Immunization type received this season: TIV (injected) LAIV (inhaled)
 If YES, <9 years old and first flu vaccination: How many vaccinations were received this season? 1 dose 2 doses

Pneumococcal vaccination ever? Yes No N/A
 If Yes: Age at receipt of pneumococcal vaccine: _____ years old N/A
 If YES: Type of vaccine: 7-valent conjugate 13-valent conjugate 23-valent polysaccharide N/A

Haemophilus influenzae type b vaccination Yes No N/A
 If Yes, age at receipt of haemophilus vaccine: _____ years old N/A

RSV immunization Palivizumab (if applicable) Yes No N/A

Are other vaccines relevant to the infection being studied? Yes No N/A
 If YES: Name of Disease _____
 If YES: Has the patient ever been vaccinated against this disease? Yes No N/A
 If YES: Age at first receipt of vaccine: _____ years N/A Number of doses received to date: _____ N/A
 If YES: Time since last dose: ≥14 days prior to illness <14 days prior to illness N/A

Any other relevant details: _____

SUPPLEMENTARY CASE RECORD FORM - Severe Acute Respiratory Infection



PARTICIPANT IDENTIFICATION #: [][][]- [][][][]

SPRINT SARI INCLUSION CRITERIA

Suspected or proven acute respiratory infection YES NO

New admission with symptom onset within the previous 14 days: YES NO (required for inclusion)

Experience of the following symptoms during this illness episode: (one or more required for inclusion)

- A history of feverishness or measured fever of $\geq 38^{\circ}\text{C}$: YES NO
- Cough: YES NO
- Dyspnoea (shortness of breath) OR Tachypnoea*: YES NO

** respiratory rate ≥ 50 breaths/min for <1 year; ≥ 40 breaths/min for 1-4 years; ≥ 30 breaths/min for 5-12 years; ≥ 20 breaths/min for ≥ 13 years*