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 taking biological samples for research purposes: complete a DAILY CRF on each day that research samples are taken.** – For sites with available resources.

Additional CRF modules are available (e.g. study-specific inclusion criteria, epidemiology, pharmacokinetics) 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 (if you register as a network), 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 (O) are multiple selection answers (choose as many answers as are applicable).
- Mark 'N/A' for any results of laboratory values that 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 data@iddo.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

World Health Organization ISARIC

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: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

2. DEMOGRAPHICS

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

3. ONSET & ADMISSION

Symptom onset date of first/earliest symptom: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Admission date at this facility: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

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: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

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

Mechanical ventilation ☐YES ☐NO ☐N/A **FiO_2** *(0.21-1.0)* [___].[___][___] or [___][___]L/min

SaO_2 *at time of FiO_2*[___][___][___]% **PaO_2** *at time of FiO_2* [___][___][___]☐kPa *or* ☐mmHg

Platelet Count [___][___][___][___]x10 9/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: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] **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

Outcome date: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

CORE CASE RECORD FORM - Severe Acute Respiratory Infection

World Health Organization ISARIC

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

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

World Health Organization ISARIC

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:** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

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)*: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

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

World Health Organization   ISARIC

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	☐YES ☐NO ☐N/A	Cardiac arrest	☐YES ☐NO ☐N/A
Bacterial pneumonia	☐YES ☐NO ☐N/A	Bacteraemia	☐YES ☐NO ☐N/A
Acute lung injury / Acute Respiratory Distress Syndrome	☐YES ☐NO ☐N/A	Coagulation disorder / Disseminated Intravascular Coagluation	☐YES ☐NO ☐N/A
Pneumothorax	☐YES ☐NO ☐N/A	Anaemia	☐YES ☐NO ☐N/A
Pleural effusion	☐YES ☐NO ☐N/A	Rhabdomyolysis / Myositis	☐YES ☐NO ☐N/A
Bronchiolitis	☐YES ☐NO ☐N/A	Acute renal injury/ Acute renal failure	☐YES ☐NO ☐N/A
Meningitis / Encephalitis	☐YES ☐NO ☐N/A	Gastrointestinal haemorrhage	☐YES ☐NO ☐N/A
Seizure	☐YES ☐NO ☐N/A	Pancreatitis	☐YES ☐NO ☐N/A
Stroke / Cerebrovascular accident	☐YES ☐NO ☐N/A	Liver dysfunction	☐YES ☐NO ☐N/A
Congestive heart failure	☐YES ☐NO ☐N/A	Hyperglycemia	☐YES ☐NO ☐N/A
Endocarditis / Myocarditis / Pericarditis	☐YES ☐NO ☐N/A	Hypoglycemia	☐YES ☐NO ☐N/A
Cardiac arrhythmia	☐YES ☐NO ☐N/A	Other	☐YES ☐NO ☐N/A
Cardiac ischaemia	☐YES ☐NO ☐N/A	*Specify:* ______________________	

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__ __	☐Nasal/NP swab ☐Throat swab ☐Combined nasal/NP+throat swab ☐Sputum ☐BAL ☐ETA ☐Urine ☐Feces/rectal swab ☐Blood ☐Other, *Specify:* ______________	☐PCR ☐Culture ☐Other, *Specify:* __________	☐Positive ☐Negative ☐N/A	______________
__ __/__ __/20__ __	☐Nasal/NP swab ☐Throat swab ☐Combined nasal/NP+throat swab ☐Sputum ☐BAL ☐ETA ☐Urine ☐Feces/rectal swab ☐Blood ☐Other, *Specify:* ______________	☐PCR ☐Culture ☐Other, *Specify:* __________	☐Positive ☐Negative ☐N/A	______________
__ __/__ __/20__ __	☐Nasal/NP swab ☐Throat swab ☐Combined nasal/NP+throat swab ☐Sputum ☐BAL ☐ETA ☐Urine ☐Feces/rectal swab ☐Blood ☐Other, *Specify:* ______________	☐PCR ☐Culture ☐Other, *Specify:* __________	☐Positive ☐Negative ☐N/A	______________
__ __/__ __/20__ __	☐Nasal/NP swab ☐Throat swab ☐Combined nasal/NP+throat swab ☐Sputum ☐BAL ☐ETA ☐Urine ☐Feces/rectal swab ☐Blood ☐Other, *Specify:* ______________	☐PCR ☐Culture ☐Other, *Specify:* __________	☐Positive ☐Negative ☐N/A	______________
__ __/__ __/20__ __	☐Nasal/NP swab ☐Throat swab ☐Combined nasal/NP+throat swab ☐Sputum ☐BAL ☐ETA ☐Urine ☐Feces/rectal swab ☐Blood ☐Other, *Specify:* ______________	☐PCR ☐Culture ☐Other, *Specify:* __________	☐Positive ☐Negative ☐N/A	______________

World Health Organization ISARIC

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

World Health Organization ISARIC

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)*:

☐Multi-organ dysfunction syndrome	☐Acute lung injury	☐Pneumonia	☐Myocardial infarction
☐Congestive heart failure	☐Dysrhythmia	☐Chronic obstructive lung disease	☐Pulmonary emboli
☐Cerebrovascular disease	☐Renal failure	☐Liver failure	☐Malignant neoplasm
☐Other, specify: _____			☐N/A

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

○Multi-organ dysfunction syndrome	○Acute lung injury	○Pneumonia	○Myocardial infarction
○Congestive heart failure	○Dysrhythmia	○Chronic obstructive lung disease	○Pulmonary emboli
○Cerebrovascular disease	○Renal failure	○Liver failure	○Malignancy
○Other, specify: _____		○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

World Health Organization ISARIC

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):* [_D_][_D_]/[_M_][_M_]/[__2_][__0_][_Y_][_Y_] *(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')*:

FiO_2 *(0.21-1.0)* [___].[___][___] or [___][___]L/min **SaO_2** [___][___][___]%

PaO_2 *at time of FiO_2 above* [___][___][___] ☐kPa *or* ☐mmHg **PaO_2 sample type:** ☐ Arterial ☐ Venous ☐ Capillary ☐N/A

From same blood gas record as PaO_2 **PCO_2** _____☐kPa *or* ☐mmHg **pH** _____

HCO_3- _____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/k/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** _____ ☐x10^9/L *or* ☐x10^3/µL

Platelets _____ ☐x10^9/L *or* ☐x10^3/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/d **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

World Health Organization ISARIC

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

World Health Organization ISARIC

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

EXTRA SPACE FOR INFORMATION ON THE CORE DATA FORM - CONTINUED

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 database at https://www.cliresdms.org

CORE - SECTION 2 – ADMISSION IMMUNOSUPPRESSANT: Receiving immunosuppressants (including oral (not inhaled) corticosteroids) prior to admission? *Enter the details below.*

Name of immunosuppressant	Dose and frequency	Route of administration	Duration
	☐unknown	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A	☐days ☐weeks ☐N/A
	☐unknown	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A	☐days ☐weeks ☐N/A
	☐unknown	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A	☐days ☐weeks ☐N/A
	☐unknown	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A	☐days ☐weeks ☐N/A
	☐unknown	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A	☐days ☐weeks ☐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
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A

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

World Health Organization   ISARIC

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

EXTRA SPACE FOR INFORMATION ON THE CORE DATA FORM - CONTINUED

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 database at https://www.cliresdms.org

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__ __	☐Nasal/NP swab ☐Throat swab ☐Combined nasal/NP+throat swab ☐Sputum ☐BAL ☐ETA ☐Urine ☐Feces/rectal swab ☐Blood ☐Other, *Specify:* ____________________	☐PCR ☐Culture ☐Other, *Specify:* ______________	☐Positive ☐Negative ☐N/A	__________________
__ __/__ __/20__ __	☐Nasal/NP swab ☐Throat swab ☐Combined nasal/NP+throat swab ☐Sputum ☐BAL ☐ETA ☐Urine ☐Feces/rectal swab ☐Blood ☐Other, *Specify:* ____________________	☐PCR ☐Culture ☐Other, *Specify:* ______________	☐Positive ☐Negative ☐N/A	__________________
__ __/__ __/20__ __	☐Nasal/NP swab ☐Throat swab ☐Combined nasal/NP+throat swab ☐Sputum ☐BAL ☐ETA ☐Urine ☐Feces/rectal swab ☐Blood ☐Other, *Specify:* ____________________	☐PCR ☐Culture ☐Other, *Specify:* ______________	☐Positive ☐Negative ☐N/A	__________________
__ __/__ __/20__ __	☐Nasal/NP swab ☐Throat swab ☐Combined nasal/NP+throat swab ☐Sputum ☐BAL ☐ETA ☐Urine ☐Feces/rectal swab ☐Blood ☐Other, *Specify:* ____________________	☐PCR ☐Culture ☐Other, *Specify:* ______________	☐Positive ☐Negative ☐N/A	__________________
__ __/__ __/20__ __	☐Nasal/NP swab ☐Throat swab ☐Combined nasal/NP+throat swab ☐Sputum ☐BAL ☐ETA ☐Urine ☐Feces/rectal swab ☐Blood ☐Other, *Specify:* ____________________	☐PCR ☐Culture ☐Other, *Specify:* ______________	☐Positive ☐Negative ☐N/A	__________________
__ __/__ __/20__ __	☐Nasal/NP swab ☐Throat swab ☐Combined nasal/NP+throat swab ☐Sputum ☐BAL ☐ETA ☐Urine ☐Feces/rectal swab ☐Blood ☐Other, *Specify:* ____________________	☐PCR ☐Culture ☐Other, *Specify:* ______________	☐Positive ☐Negative ☐N/A	__________________
__ __/__ __/20__ __	☐Nasal/NP swab ☐Throat swab ☐Combined nasal/NP+throat swab ☐Sputum ☐BAL ☐ETA ☐Urine ☐Feces/rectal swab ☐Blood ☐Other, *Specify:* ____________________	☐PCR ☐Culture ☐Other, *Specify:* ______________	☐Positive ☐Negative ☐N/A	__________________

World Health Organization ISARIC

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

EXTRA SPACE FOR INFORMATION ON THE CORE DATA FORM - CONTINUED

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 database at https://www.cliresdms.org

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**
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A
	☐N/A	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐Oral ☐Inhaled ☐Other ☐N/A

World Health Organization ISARIC

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) ☐QIV (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: _____

World Health Organization ISARIC

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

PHARMACOKINETIC INVESTIGATIONS (Tier 3)

Pharmacokinetic data can be collected on this form. All information should be entered into the appropriate sections of the electronic database at https://www.cliresdms.org

PHARMACOKINETICS (PK)

Drug under study:	________________________
Start date of drug prescription:	**Date:** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Date of PK sampling listed below ***(one page per day):***	**Date:** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Prescribed times of administration:	**Specify All:** ____
***Precise* time of 1st PK sampling:**	**Time** ***(24 hour clock H H : M M)*** ___ ___ : ___ ___
***Precise* time of 2nd PK sampling:**	**Time** ***(24 hour clock H H : M M)*** ___ ___ : ___ ___
***Precise* time of 3rd PK sampling:**	**Time** ***(24 hour clock H H : M M)*** ___ ___ : ___ ___
***Precise* time of 4th PK sampling:**	**Time** ***(24 hour clock H H : M M)*** ___ ___ : ___ ___

Record all doses of the drug under study given on the PK sampling day and in the 24hrs preceding the first PK sampling:

Dose:	**Route of administration**	***Precise* Time Drug Given** ***(if infusion: Start Time)*** ***(24 hour clock HH:MM)***	***Precise* End Time** ***(infusion only)*** ***(24 hour clock HH:MM)***
Amount: ___________ **Units:**____________	☐IV ☐Oral ☐Inhaled ☐Other:_______________	___ ___ : ___ ___ ☐Same day as PK sample(s) ☐Day before PK sample(s)	___ ___ : ___ ___ ☐Same day as PK sample(s) ☐Day before PK sample(s)
Amount: ___________ **Units:**____________	☐IV ☐Oral ☐Inhaled ☐Other:_______________	___ ___ : ___ ___ ☐Same day as PK sample(s) ☐Day before PK sample(s)	___ ___ : ___ ___ ☐Same day as PK sample(s) ☐Day before PK sample(s)
Amount: ___________ **Units:**____________	☐IV ☐Oral ☐Inhaled ☐Other:_______________	___ ___ : ___ ___ ☐Same day as PK sample(s) ☐Day before PK sample(s)	___ ___ : ___ ___ ☐Same day as PK sample(s) ☐Day before PK sample(s)
Amount: ___________ **Units:**____________	☐IV ☐Oral ☐Inhaled ☐Other:_______________	___ ___ : ___ ___ ☐Same day as PK sample(s) ☐Day before PK sample(s)	___ ___ : ___ ___ ☐Same day as PK sample(s) ☐Day before PK sample(s)
Amount: ___________ **Units:**____________	☐IV ☐Oral ☐Inhaled ☐Other:_______________	___ ___ : ___ ___ ☐Same day as PK sample(s) ☐Day before PK sample(s)	___ ___ : ___ ___ ☐Same day as PK sample(s) ☐Day before PK sample(s)
Amount: ___________ **Units:**____________	☐IV ☐Oral ☐Inhaled ☐Other:_______________	___ ___ : ___ ___ ☐Same day as PK sample(s) ☐Day before PK sample(s)	___ ___ : ___ ___ ☐Same day as PK sample(s) ☐Day before PK sample(s)

World Health Organization ISARIC

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 ≥ 38°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*