

Global COVID-19 Clinical Platform WITH PREGNANCY MODULE – CRF-P

INTRODUCTION

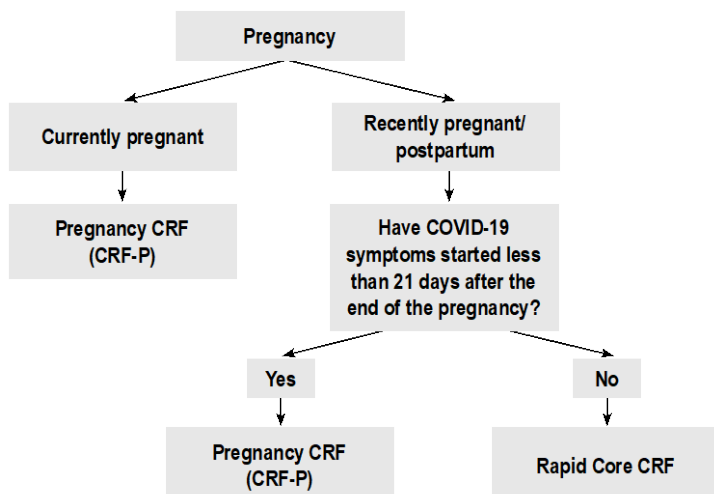
In response to the COVID-19 pandemic, the World Health Organization (WHO) has launched a global COVID-19 anonymized clinical data platform (the “COVID-19 Data Platform”) to enable State Parties to the International Health Regulations (IHR) (2005) to share with WHO anonymized clinical data related to patients with suspected or confirmed infections with SARS-CoV-2 (collectively “anonymized COVID-19 data”). The anonymized COVID-19 data received by WHO will remain the property of the contributing Entity and will be used by WHO for purposes of verification, assessment and assistance pursuant to the IHR (2005), including to inform the public health and clinical operation response in connection with the COVID-19 outbreak. To help achieve these objectives, WHO has established an independent Clinical Advisory Group to advise WHO on global reporting and analysis of the anonymized clinical COVID-19 data. State Parties and other entities are invited to contact WHO to obtain more information about how to contribute anonymized clinical COVID-19 data to the WHO Data Platform. To preserve the security and confidentiality of the anonymized COVID-19 data, State Parties and other entities are respectfully requested to take all necessary measures to protect their respective log-in credentials and passwords to the COVID-19 Data Platform.

The anonymized COVID-19 data will be stored in the WHO COVID-19 Data Platform, which is a secured, access-limited, password protected electronic platform. WHO will (i) protect the confidentiality and prevent the unauthorized disclosure of the anonymized COVID-19 data; (ii) implement and maintain appropriate technical and organizational security measures to protect the security of the anonymized COVID-19 data and the COVID-19 Data Platform. In accordance with Article 11(4) of the IHR (2005), WHO will not make the anonymized COVID-19 data generally available to other State Parties or entities until such time as any of the conditions set forth in paragraph 2 of Article 11 are first met, and following consultation with affected countries/entities. Pursuant to that same Article 11, WHO will not make the anonymized COVID-19 data available to the public, unless and until the anonymized COVID-19 data have already been made available to State Parties, and provided that other information about the COVID-19 epidemic has already become publicly available and there is a need for the dissemination of authoritative and independent information. To contribute data to the WHO COVID-19 Data Platform or to receive more information, please contact:

COVID_ClinPlatform@who.int

DESIGN OF THIS PREGNANCY MODULE CASE REPORT FORM (CRF-P)

The CRF is designed to collect data obtained through examination, interview and review of hospital notes. Data may be collected retrospectively if the patient data are obtained after the admission date. The data collection period is defined as the period from hospital admission to discharge, transfer, death, or continued hospitalization without possibility of continued data collection. **This CRF-P should be completed for pregnant women or recently pregnant women who delivered within 21 days from onset of symptoms. If COVID symptoms started more than 21 days after the end of the pregnancy, please complete the Rapid Core CRF only.**



The Pregnancy CRF has 3 sections:

Module 1: to be completed on the first day of admission to the health centre.

Module 2: to be completed daily during hospital stay for as many days as resources allow. Continue to follow-up patients who transfer between wards.

Module 3: to be completed at discharge or death.

GENERAL GUIDANCE

Participant identification numbers consist of a site code and a participant number. Please contact us at COVID_ClinPlatform@who.int, and our data management team will provide you with instructions for data entry and will assign you a 5-digit site code at that time.

PREGNANCY MODULE 1. Complete on hospital admission (within 24 hrs from hospital admission)

Facility name: _____ Country: _____

Date of enrolment: [D][D]/[M][M]/[2][0][Y][Y]

1a. CLINICAL INCLUSION CRITERIA

One or more		A history of self-reported feverishness or measured fever of $\geq 38^{\circ}\text{C}$	<input type="checkbox"/> Yes <input type="checkbox"/> No
of these		Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
during this		Dyspnoea (shortness of breath) OR Tachypnoea*	<input type="checkbox"/> Yes <input type="checkbox"/> No
illness		Clinical suspicion despite not meeting criteria above	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

1b. DEMOGRAPHICS

 Sex at birth Male Female Not specified Date of birth [D][D]/[M][M]/[Y][Y][Y][Y]

If date of birth is unknown, record: Age [][] years OR [][] months OR [][] days

 Health care worker? Yes No Unknown Laboratory worker? Yes No Unknown

 Pregnant?* Yes No Unknown N/A If yes: Gestational weeks assessment [][] weeks

If currently pregnant or recently pregnant (delivery within 21 days of symptom onset), complete all sections of this CRF
1c. DATE OF ONSET AND ADMISSION VITAL SIGNS (first available data at presentation/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]

Temperature [][] °C Heart rate [][] beats/min

Respiratory rate [][] breaths/min

 BP [][] (systolic) [][] (diastolic) mmHg Severe dehydration Yes No Unknown

 Sternal capillary refill time > 2 seconds Yes No Unknown

 Oxygen saturation: [][]% on Room air Oxygen therapy Unknown **A V P U** (circle one)

 Glasgow Coma Score (GCS/15) [][] Malnutrition Yes No Unknown

Mid-upper arm circumference [][] mm Height: [][] cm Weight: [][] kg

1d. CO-MORBIDITIES (existing at admission) (Unk = Unknown)

Chronic cardiac disease (not hypertension)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Current smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chronic pulmonary disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Tuberculosis (active)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Tuberculosis (previous)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chronic kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Asplenia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chronic liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Malignant neoplasm	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chronic neurological disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
		If yes, specify:	
HIV	<input type="checkbox"/> Yes (on ART) <input type="checkbox"/> Yes (not on ART) <input type="checkbox"/> No <input type="checkbox"/> Unknown	ART regimen	_____

1e. PRE-ADMISSION AND CHRONIC MEDICATION Were any of the following taken within 14 days of admission:

Angiotensin converting enzyme inhibitors (ACE inhibitors)? Yes No Unknown
Angiotensin II receptor blockers (ARBs)? Yes No Unknown
Non-steroidal anti-inflammatory (NSAID)? Yes No Unknown
Antiviral? Chloroquine/hydroxychloroquine Azithromycin Lopinavir/Ritonavir Other: _____

1f. SIGNS AND SYMPTOMS Reported/assessed on the day of **ADMISSION** (*Unk = Unknown*)

History of fever	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Lower chest indrawing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
with sputum production	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Altered consciousness/confusion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
with haemoptysis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Runny nose	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Vomiting/nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Diarrhoea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Conjunctivitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Muscle aches	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Skin rash	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Joint pain (arthralgia).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Skin ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Fatigue/malaise	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Lymphadenopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Loss of taste	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Inability to walk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Loss of smell	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Bleeding (haemorrhage)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If bleeding, specify site(s):	
Stroke: ischaemic stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Stroke: intracerebral haemorrhage	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
If yes, specify: _____			

1g. MEDICATION On the day of admission, did the patient receive any of the following:

Oral/orogastric fluids? Yes No Unknown **Intravenous fluids?** Yes No Unknown
Antiviral? Yes No Unknown
If yes: Ribavirin Lopinavir/Ritonavir Neuraminidase inhibitor
Interferon alpha Interferon beta Other, specify: _____
Corticosteroid? Yes No Unknown **If yes, route:** Oral Intravenous Inhaled
If yes, please provide agent and maximum daily dose: _____
Antibiotic? Yes No Unknown **If yes, specify:** _____
Antifungal agent? Yes No Unknown
Antimalarial agent? Yes No Unknown **If yes, specify:** _____
Experimental agent? Yes No Unknown **If yes, specify:** _____
Non-steroidal anti-inflammatory (NSAID) Yes No Unknown
Angiotensin converting enzyme inhibitors (ACE inhibitors) Yes No Unknown
Angiotensin II receptor blockers (ARBs) Yes No Unknown
Systemic anticoagulation Yes No Unknown

1h. SUPPORTIVE CARE On the day of admission, did the patient receive any of the following:
ICU or high dependency unit admission? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Oxygen therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes , complete all below O ₂ flow: <input type="checkbox"/> 1–5 L/min <input type="checkbox"/> 6–10 L/min <input type="checkbox"/> 11–15 L/min <input type="checkbox"/> > 15 L/min <input type="checkbox"/> Unknown Source of oxygen: <input type="checkbox"/> Piped <input type="checkbox"/> Cylinder <input type="checkbox"/> Concentrator <input type="checkbox"/> Unknown Interface: <input type="checkbox"/> Nasal prongs <input type="checkbox"/> HF nasal cannula <input type="checkbox"/> Mask <input type="checkbox"/> Mask with reservoir <input type="checkbox"/> CPAP/NIV mask <input type="checkbox"/> Unknown Non-invasive ventilation? (e.g. BIPAP/CPAP) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Invasive ventilation (any)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, what were the following values closest to 08:00: PEEP (cm H ₂ O) _____; FiO ₂ (%) _____; Plateau pressure (cm H ₂ O) _____; PaCO ₂ _____; PaO ₂ _____ Extracorporeal (ECMO) support? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Prone position? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Inotropes/vasopressors? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

1i. LABORATORY RESULTS ON ADMISSION (*record units if different from those listed)							
Parameter	Value*	Units		Parameter	Value*	Units	
Haemoglobin		<input type="checkbox"/> g/L	<input type="checkbox"/> g/dL	Creatinine		<input type="checkbox"/> mg/L	<input type="checkbox"/> µmol/L
WBC count		<input type="checkbox"/> /mm ³	<input type="checkbox"/> G/L (= x10 ⁹ /L)	Sodium		<input type="checkbox"/> mEq/L = mmol/L	
Haematocrit		<input type="checkbox"/> %		Potassium		<input type="checkbox"/> mEq/L = mmol/L	
Platelets		<input type="checkbox"/> /mm ³	<input type="checkbox"/> G/L (= x10 ⁹ /L)	Procalcitonin		<input type="checkbox"/> ng/mL	<input type="checkbox"/> µg/L
APTT/APTR		<input type="checkbox"/> seconds		CRP		<input type="checkbox"/> mg/L	
PT (seconds)		<input type="checkbox"/> seconds		LDH		<input type="checkbox"/> IU/L	
INR				Creatine kinase		= <input type="checkbox"/> = IU/L	<input type="checkbox"/> UKAT/L
ALT/SGPT		<input type="checkbox"/> IU/L		Troponin		<input type="checkbox"/> ng/mL	<input type="checkbox"/> µg/L
AST/SGOT		<input type="checkbox"/> IU/L		ESR		<input type="checkbox"/> mm/hour	
Total bilirubin		<input type="checkbox"/> mg/L	<input type="checkbox"/> µmol/L	D-dimer		<input type="checkbox"/> ng/mL	<input type="checkbox"/> µg/L
Urea (BUN)		<input type="checkbox"/> g/L	<input type="checkbox"/> mg/dL	<input type="checkbox"/> mmol/L	Ferritin	<input type="checkbox"/> ng/mL	<input type="checkbox"/> µg/L
Lactate		<input type="checkbox"/> mg/dL	<input type="checkbox"/> mmol/L	IL-6		<input type="checkbox"/> pg/mL	

1j. PREGNANCY STATUS UPON ADMISSION
Pregnant not in labour <input type="checkbox"/> Pregnant in labour <input type="checkbox"/> Postpartum [days]* <input type="checkbox"/> [days] Breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No Post-abortion/miscarriage <input type="checkbox"/> Number of fetuses <input type="checkbox"/> Singleton <input type="checkbox"/> Twin <input type="checkbox"/> Triplet <input type="checkbox"/> Other [number] <input type="checkbox"/> Unknown Best estimate of gestational age in completed weeks [_ W _] [_ W _] weeks

1k. ABORTION OR MISCARRIAGE (prior to admission)	
Date of induced abortion or spontaneous abortion/miscarriage?	[_D_] [_D_] / [_M_] [_M_] / [_2_] [_0_] [_Y_] [_Y_]]
Were symptoms of COVID-19 disease present at the time?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

1l. OBSTETRIC HISTORY
Number of previous pregnancies beyond 22 weeks gestation [number]
Number of previous vaginal deliveries [number]
Number of previous cesarean deliveries [number]

1m. Please tick any which apply to previous deliveries:	
Preterm birth (< 37 weeks' gestation)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Congenital anomaly	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Stillborn	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Neonatal death (0–6 days)	<input type="checkbox"/> Yes [day:] <input type="checkbox"/> No <input type="checkbox"/> Unknown
Weight < 2.5 kg	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Weight > 4.5 kg	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

1n. ALCOHOL, DRUGS – RISK FACTORS DURING THIS PREGNANCY	
Alcohol consumption	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Illicit/recreational drug use	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

1o. MEDICATIONS DURING THIS PREGNANCY (Prior to onset of current illness episode)	
Fever or pain treatment	Acetaminophen/paracetamol <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	NSAID/s <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Other/s (specify): [_____]
Anticonvulsants	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify generic name: [_____]
Anti-nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify generic name: [_____]
Prenatal vitamins and micronutrients	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify generic name: [_____]
Antivirals	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify generic name: [_____]
Antibiotics	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify generic name: [_____]

1p. ADMISSION SIGNS AND SYMPTOMS			
Vaginal watery discharge	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Vaginal bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Vision changes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Right upper quadrant (abdominal) pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Decreased or no fetal movement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Uterine contractions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

1q. FETAL HEART RATE <i>(first available data at presentation/admission)</i>	
Fetal heart rate	(FHR): [][][] beats/min

PREGNANCY MODULE 2. Follow up (daily or as frequent as possible based on feasibility)

Date of follow up [D][D]/[M][M]/[2][0][Y][Y]

2a. VITAL SIGNS (record most abnormal value between 00:00 to 24:00)	
Temperature [][.][] °C	Heart rate [][] beats per min
Respiratory rate [][] breaths/min	BP [][] [][] (systolic) [][] [][] (diastolic) mmHg
Severe dehydration <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Sternal capillary refill time > 2 seconds <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Oxygen saturation [][] [][] % on <input type="checkbox"/> Room air <input type="checkbox"/> Oxygen therapy <input type="checkbox"/> Unknown	A V P U (circle one)
	GCS/15 [][] [][]

2b. DAILY CLINICAL FEATURES (Unk = Unknown)			
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Confusion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
and sputum production	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Vomiting/nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Diarrhoea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Conjunctivitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Loss of smell	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Myalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Loss of taste	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Other, specify: _____	

2c. LABORATORY RESULTS (*record units if different from those listed)							
Parameter	Value*	Units		Parameter	Value*	Units	
Haemoglobin		__ g/L	__ g/dL	Creatinine		__ mg/L	__ µmol/L
WBC count		__ /mm ³	__ G/L (= x10 ⁹ /L)	Sodium		__ mEq/L = mmol/L	
Haematocrit		__ %		Potassium		__ mEq/L = mmol/L	
Platelets		__ /mm ³	__ G/L (= x10 ⁹ /L)	Procalcitonin		__ ng/mL	__ µg/L
APTT/APTR		__ seconds		CRP		__ mg/L	
PT (seconds)		__ seconds		LDH		__ IU/L	
INR				Creatine kinase		__ IU/L	__ UKAT/L
ALT/SGPT		__ IU/L		Troponin		__ ng/mL	__ µg/L
AST/SGOT		__ IU/L		ESR		__ mm/hour	
Total bilirubin		__ mg/L	__ µmol/L	D-dimer		__ ng/mL	__ µg/L
Urea (BUN)		__ g/L	__ mg/dL	Ferritin		__ ng/mL	__ µg/L
Lactate		__ mg/dL	__ mmol/L	IL-6		__ pg/mL	

2d. MEDICATION At any time during this 24-hour hospital day, did the patient receive:

Oral/orogastric fluids? Yes No Unknown **Intravenous fluids?** Yes No Unknown
Antiviral? Yes No Unknown **If yes:** Ribavirin Lopinavir/Ritonavir Neuraminidase inhibitor
Interferon alpha Interferon beta Other, specify: _____
Corticosteroid? Yes No Unknown **If yes, route:** Oral Intravenous Inhaled
If yes, please provide agent and maximum daily dose: _____
Antibiotic? Yes No Unknown **Antifungal agent?** Yes No Unknown
Antimalarial agent? Yes No Unknown **If yes, specify:** _____
Experimental agent? Yes No Unknown **If yes, specify:** _____
Non-steroidal anti-inflammatory (NSAID) Yes No Unknown
Angiotensin converting enzyme inhibitors (ACE inhibitors) Yes No Unknown
Angiotensin II receptor blockers (ARBs) Yes No Unknown
Systemic anticoagulation Yes No Unknown

2e. SUPPORTIVE CARE At any time during this 24-hour hospital day, did the patient receive:

ICU or high dependency unit admission? Yes No Unknown
Date of ICU/HDU admission [_] [_] / [_] [_] / [2] [0] [_] [_] Unknown
ICU/HDU discharge date [_] [_] / [_] [_] / [2] [0] [_] [_] Not discharged yet Unknown
Oxygen therapy? Yes No Unknown **If yes, complete all below:**
O₂ flow: 1–5 L/min 6–10 L/min 11–15 L/min > 15 L/min Unknown
Source of oxygen: Piped Cylinder Concentrator Unknown
Interface: Nasal prongs HF nasal cannula Mask Mask with reservoir CPAP/NIV mask Unknown
Non-invasive ventilation? (e.g. BIPAP, CPAP) Yes No Unknown
Invasive ventilation (any)? Yes No Unknown **If yes, what were the following values closest to 08:00:** PEEP (cm H₂O) _____; FiO₂ (%) _____; Plateau pressure (cm H₂O) _____; PaCO₂ _____; PaO₂ _____
Extracorporeal (ECMO) support? Yes No Unknown
Prone position? Yes No Unknown
Inotropes/vasopressors? Yes No Unknown
Renal replacement therapy (RRT) or dialysis? Yes No Unknown

2f. FETAL HEART RATE

Fetal heart rate (record most abnormal value between 00:00 to 24:00)	(FHR): [_] [_] [_] beats/min
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2g. TREATMENT DURING HOSPITALIZATION
At ANY time during hospitalization, did the patient receive/undergo:

Tocolysis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Induction of labour	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Blood transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

