ISARIC HANTAVIRUS CRF

DESIGN OF THIS CASE REPORT FORM (CRF)

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

PRESENTATION FORM: ALWAYS complete on the first day of presentation/admission/assessment.
DAILY FORM: ALWAYS complete on the first day of presentation/admission/assessment
DAILY FORM: IF APPLICABLE, complete on the day of admission to ICU/high dependency unit/critical care (if different date to the date of first presentation/admission)
DAILY FORM: OPTION to complete on days that research specific samples are taken
DAILY FORM: OPTION to complete daily if of interest for specific analysis.
OUTCOME FORM: ALWAYS complete at discharge or death or at the end of the study period
Continue to follow-up patients who transfer between wards.

Forms	Hospital admission / initial assessment	Admission to ICU (if applicable)	Research sample taken (optional)	As per site protocol (optional)	Discharge / death / end of study
PRESENTATION FORM	COMPLETE				
DAILY FORM	COMPLETE	(COMPLETE)	(COMPLETE)	(COMPLETE)	
OUTCOME FORM					COMPLETE
FOLLOW-UP FORM				(COMPLETE)	
WITHDRAWAL FORM				(COMPLETE)	

GENERAL GUIDANCE

• Contact ISARIC Global Support Centre at data@isaric.org
• The CRF is designed to collect data obtained through examination, interview, review of hospital notes, or extraction from electronic health records. Data may be collected prospectively or retrospectively if the patient is enrolled after the date of presentation to a health facility.
• Please refer to the CRF Completion Guideline for detailed guidance on how to complete these forms.
• Your institution may capture data:
(a) on the ISARIC hosted REDCap database - contact ISARIC for access,
(b) to a REDCap database hosted at your institution - contact ISARIC if you would like support to set this up, or
(c) on a database or electronic health record system at your institution - contact ISARIC to support data mapping.
• Participant Identification Numbers consist of a 5-digit site code and a 4-digit participant number.
Please obtain a site code and register on the data management system by contacting ISARIC. Participant numbers should be assigned sequentially for each site beginning with 0001 or in blocks, possibly including alpha characters, where useful. E.g., Ward X will assign numbers from 0001 or A001 onwards and Ward Y will assign numbers from 5001 or B001 onwards.
• For participants who return for re-admission to the same site, start a new form with a different Participant Identification Number. Please check "YES-admitted previously to this facility" in the RE-ADMISSION section. Enter as 2 separate records if you are using a REDCap (or similar) database.
• For participants who transfer between two sites that are both collecting data on this form, it is preferred to have the data entered by a single site as a single admission, under the same Participant Identification Number. When this is not possible, the first site should record "Transfer to other facility" as an OUTCOME, and the second site should start a new form with a new patient number and indicate "YES-… then transferred to this facility" in the RE-ADMISSION AND PREVIOUS PIN section.
• Selections with circles (○) are single selection (choose one answer only). Selections with square boxes (□) are multiple selection (choose as many answers as are applicable). Unk = Unknown

INCLUSION CRITERIA

Participant Identification Number (PIN): enter CPMS site code (hyphen) four digit number patient number (e.g. Y0401-0001 or UKHSA-0001 if no site code available).	_____	Date of Enrolment	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]
Site location	_____		

INCLUSION CRITERIA

Proven or suspected hantavirus infection	○ Yes ○ No		
High suspicion of exposure to hantavirus	○ Yes ○ No	If Yes: Which of the following is the individual proven/suspected of having or exposed to?	☐ Andes virus infection (hantavirus) ☐ Other ☐ Unknown _____

CONSENT

CONSENT - As a research professional I certifying that consent has been documented			
In Scotland and Northern Ireland, I certify that consent has been obtained for collection of confidential data including personal identifiers: N.B. Under Regulation 3 of The Health Service (Control of Patient Information) Regulations 2002 (COPI), consent is not required for the collection of confidential patient information with personal identifiers (data) in England and Wales during an event of public health interest or its aftermath.	○ Yes ○ No ○ N/K	In all countries of the UK, consent has been obtained for the collection of samples including DNA:	○ Yes ○ No ○ N/K
Consent options (select all to which the patient agreed):	☐ Data and samples may be used for other unrelated ethically approved research in the UK or elsewhere ☐ Data and samples can be used to manufacture tests, treatments, or other products, including commercial products ☐ De-identified data and results of analyses, can be shared with other scientists, including those in other countries ☐ Participant may be contacted by the investigators to be invited to participate in future work, including research studies		

PRESENTATION

ONSET & PRESENTATION

Onset date of first / earliest symptom	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]	Date of first clinical consultation	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]
Most recent present ation/admission date at this facility	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]		
Admitted to hospital	○ Yes ○ No ○ Unknown	If Yes: Reason for hospitalisation	○ Infection of interest ○ Other

DEMOGRAPHICS

Is the date of birth known?	○ Yes ○ No				
If Yes: Date of birth	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]	If No: Age	_____ ○Years ○Months ○Days		
Sex at birth	○ Male ○ Female ○ Not specified/Unknown ○ Other _____	Gender	○ Male ○ Female ○ Non-binary ○ Unknown ○ Other _____	Height	_____ ○cm ○in
Weight	_____ ○kg ○lb				
Employed as a healthcare worker	○ Yes ○ No ○ Unknown	If Yes:			
Patient facing	○ Yes ○ No ○ Unknown	Exposed to biological samples	○ Yes ○ No ○ Unknown		
Does the patient practise any of these professions or a profession related to their infection	○ Abattoir Worker ○ Beef Cattle Farm Worker ○ Dairy Farm Worker ○ Healthcare Worker ○ Live bird market worker ○ Other live animal market worker ○ Poultry Farm Worker ○ Poultry culler ○ Swine farm worker ○ Veterinarian ○ Other _____	Primary location of occupation	○ Home-working or unemployed ○ Indoors-office/health/education/hospitality/business/homes ○ Indoors-factory ○ Outdoors-animal contact (vet, animal farmer, abattoir worker) ○ Outdoors-agriculture/forestry/fisheries ○ Outdoors-construction/industrial/mining ○ Armed Forces ○ Student ○ Unknown ○ Other _____		
Patient's city of residence	○ Same as health care facility ○ Different from health care facility ○ Unknown _____				

EXPOSURE HISTORY IN PREVIOUS 14 DAYS

Did the patient travel outside of their home region in the past 14 days?	○ Yes ○ No ○ Unknown				
History of contact with suspected or confirmed human case of same pathogen?	○ Yes ○ No ○ Unknown		If Yes:		
Community contact	○ Yes ○ No ○ Unknown	Healthcare worker exposure	○ Yes ○ No ○ Unknown	Sexual transmission	○ Yes ○ No ○ Unknown
Family / household contacts	○ Yes ○ No ○ Unknown		Date of contact with suspected or confirmed case	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]	
Contact setting	○ Household ○ Occupational ○ Healthcare facility ○ Unknown ○ Other _____				

Exposure to confirmed or suspected case on board

Shared cabin with confirmed or suspected case	○ Yes ○ No ○ Unknown	Shared bathroom facilities with confirmed or suspected case	○ Yes ○ No ○ Unknown	Shared meals with confirmed or suspected case	○ Yes ○ No ○ Unknown
Participated in social activities with confirmed or suspected case	○ Yes ○ No ○ Unknown		Participated in shared shore/off-boat excursions with confirmed or suspected case		○ Yes ○ No ○ Unknown
Worked or spent prolonged time in the same enclosed area as confirmed or suspected case	○ Yes ○ No ○ Unknown		Cabin number (if known)	_____	
Deck/floor of cabin	_____				
Any unwell household members in the two weeks prior to the admission of case?	○ Yes ○ No ○ Unknown		If Yes: Which system(s) are affected? (tick all that apply)	☐ Respiratory ☐ Gastrointestinal ☐ Cardiovascular ☐ Central Nervous system ☐ Peripheral Nervous system ☐ Mucocutaneous ☐ Ocular ☐ Unknown ☐ Other _____	
Have household members had any contact with a confirmed case of the same infection?	○ Yes ○ No ○ Unknown				

HANTAVIRUS-SPECIFIC EXPOSURES

Exposure to rodent-contaminated environments before boarding the vessel (e.g. exposure in Argentina, shared visit to rubbish dump for birdwatching, contact with areas potentially contaminated by rodents)	○ Yes ○ No ○ Unknown	Rodent sighting or exposure on board the vessel	○ Yes ○ No ○ Unknown
Any contact with animals, animal homes, meats or other animal products in the last 14 days?	○ Yes ○ No ○ Unknown	If Yes: Date of contact with suspected or confirmed animal source	_____
Direct contact with rodents	○ Yes ○ No ○ Unknown	If Yes:	
Rodents type	☐ Rats ☐ Mice ☐ Squirrels	Specify type of contact	☐ Hunting ☐ Preparing ☐ Handling ☐ Consumption (unprocessed / undercooked / raw) ☐ Trading ☐ Animal faeces or nests ☐ Sick or dead animal ☐ Unknown ☐ Other

OTHER ANIMAL EXPOSURES

Contact with wildlife	○ Yes ○ No ○ Unknown	If Yes:	
Wildlife type	☐ Bats ☐ Other _____	Specify type of contact	☐ Hunting ☐ Preparing ☐ Handling ☐ Consumption (unprocessed / undercooked / raw) ☐ Trading ☐ Animal faeces or nests ☐ Sick or dead animal ☐ Unknown ☐ Other
Any insect or arthropod bites (eg. mosquitoes, ticks)	○ Yes ○ No ○ Unknown		
Other animal contact not listed above	○ Yes ○ No ○ Unknown	If Yes: Specify animal contacts not listed above	_____

WATER / ENVIRONMENTAL EXPOSURES

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

CO-MORBIDITIES AND RISK FACTORS: Existing prior to this current illness and is ongoing					
Chronic cardiac disease (not hypertension)	○ Yes ○ No ○ Unknown			If Yes:	
Myocardial infarction	○ Yes ○ No ○ Unknown			Congestive heart failure	○ Yes ○ No ○ Unknown
Hypertension	○ Yes ○ No ○ Unknown	Chronic pulmonary disease (not asthma)	○ Yes ○ No ○ Unknown	Asthma	○ Yes ○ No ○ Unknown
Liver disease	○ Yes ○ No ○ Unknown			If Yes: Type of liver disease	○ Mild ○ Moderate or severe ○ Unknown
Chronic kidney disease	○ Yes ○ No ○ Unknown			If Yes: Stage of chronic kidney disease	○ Stage 1 ○ Stage 2 ○ Stage 3a ○ Stage 3b ○ Stage 4 ○ Stage 5 ○ Unknown
HIV	○ Yes ○ No ○ Unknown	Tuberculosis	○ Yes ○ No ○ Unknown	Chronic hepatitis B/C infection	○ Yes ○ No ○ Unknown
Chronic haematologic disease	○ Yes ○ No ○ Unknown	Rheumatologic disorder	○ Yes ○ No ○ Unknown	Malignant neoplasm	○ Yes ○ No ○ Unknown
Obesity	○ Yes ○ No ○ Unknown			Malnutrition	○ Yes ○ No ○ Unknown
Diabetes mellitus	○ Yes ○ No ○ Unknown			If Yes:	
Diabetes mellitus type	○ Type 1 ○ Type 2 ○ Gestational diabetes ○ Unknown			End organ damage from diabetes	○ Yes ○ No ○ Unknown
Ever smoked	○ Yes ○ No ○ Unknown			If Yes: Smoking status	○ Current smoker ○ Former Smoker
Transplant recipient	○ Yes ○ No ○ Unknown			If Yes: Specify transplanted organ(s)	☐ Lung ☐ Heart ☐ Kidney ☐ Liver ☐ Bone ☐ Hematopoietic stem cell
Primary immunodeficiency	○ Yes ○ No ○ Unknown	Chemotherapy	○ Yes ○ No ○ Unknown	Radiation therapy	○ Yes ○ No ○ Unknown
Long term or high-dose corticosteroid therapy		○ Yes ○ No ○ Unknown			

Other relevant comorbidity(s)	○ Yes ○ No ○ Unknown	If Yes:	_____
Active Hepatitis C	○ Yes ○ No ○ Unknown	Active Hepatitis B	○ Yes ○ No ○ Unknown

MEDICAL HISTORY

Is the patient known to have had previous infection(s) with this pathogen?	○ Yes ○ No ○ Unknown	If Yes:	
Was the patient ever hospitalised in a previous episode of the same infection?	○ Yes-admitted to hospital or ICU ○ No ○ Unknown	When did the previous episode begin?	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]
When did the previous episode end?	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]	Was the previous episode confirmed by laboratory testing?	○ Yes ○ No ○ Unknown

MEDICATION PRIOR TO THIS ADMISSION / PRESENTATION

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

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

VACCINATION

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

SYMPTOMS ON ADMISSION: Indicate if experienced at any time from onset of this illness to the day of presentation.

Fever	○ Yes ○ No ○ Unknown	Chills or rigors	○ Yes ○ No ○ Unknown	Fatigue / malaise / lethargy	○ Yes ○ No ○ Unknown
Weakness	○ Yes ○ No ○ Unknown	Muscle aches (myalgia)	○ Yes ○ No ○ Unknown	Joint pain (arthralgia)	○ Yes ○ No ○ Unknown
Back Pain	○ Yes ○ No ○ Unknown	Cough	○ Yes ○ No ○ Unknown	Wheezing	○ Yes ○ No ○ Unknown
Shortness of breath	○ Yes ○ No ○ Unknown	Chest pain	○ Yes ○ No ○ Unknown	Abdominal pain	○ Yes ○ No ○ Unknown

Diarrhoea	○ Yes ○ No ○ Unknown				
Vomiting	○ Yes ○ No ○ Unknown		If Yes: Persistent vomiting? (>=2/day)	○ Yes ○ No ○ Unknown	
Nausea	○ Yes ○ No ○ Unknown	Anorexia	○ Yes ○ No ○ Unknown	Urinary retention	○ Yes ○ No ○ Unknown
Increased urination (polyuria)	○ Yes ○ No ○ Unknown		Pain during urination (dysuria)	○ Yes ○ No ○ Unknown	
Bleeding (haemorrhage)	○ Yes ○ No ○ Unknown		If Yes:		
Severe bleeding (requires intervention)	○ Yes ○ No ○ Unknown		Specify bleeding site(s)	☐ GI tract ☐ Gums ☐ Intra-articular ☐ Intracranial ☐ Intramuscular (with compartment syndrome) ☐ Intraocular ☐ Intraspinal ☐ Nose ☐ Pericardial ☐ Other _____	
Headache	○ Yes ○ No ○ Unknown	Photophobia	○ Yes ○ No ○ Unknown	Seizures / convulsions	○ Yes ○ No ○ Unknown
Altered consciousness / confusion	○ Yes ○ No ○ Unknown		Paralysis	○ Yes ○ No ○ Unknown	

PREGNANCY PRESENTATION

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

Baby tested for mother's infection of interest	○ Yes ○ No ○ Unknown	If Yes: If yes: specify test result from mother's infection of interest	○ Positive ○ Negative ○ Unknown

INFANT: LESS THAN 12 MONTHS OLD

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

DAILY

DAILY ASSESSMENT

DATE OF ASSESSMENT	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]	Current level of care	○ Outpatient ○ Admitted to normal ward for isolation only ○ Admitted to normal ward for clinical care ○ High dependency ○ Intensive care admission

VITAL SIGNS & ASSESSMENTS: Record the value furthest from normal range between 00:00 to 24:00 on day of assessment.

Enter Vital Signs data for this date?	○ Yes ○ No	If Yes, complete the form:			
Highest temperature	_____ ○°C ○°F	Heart Rate (bpm)	_____	Respiratory Rate (breaths/min)	_____
Systolic BP (mmHg)	_____	Diastolic BP (mmHg)	_____	Mean arterial blood pressure (mmHg)	_____
Oxygen saturation at room air (no oxygen support) (%)	_____	How was oxygen saturation at room air measured?	○ Pulse Oximetry ○ Arterial blood gas measurement ○ Other ○ Unknown		
Supplemental oxygen?	○ Yes ○ No ○ Unknown	If Yes:			
Type of supplemental oxygen?	○ Nasal Prongs ○ Face mask ○ High flow nasal oxygen ○ Non-invasive ventilation ○ Invasive ventilation ○ ECMO / ECLS ○ Unknown	Oxygen saturation with supplemental oxygen (%)	_____		
How was oxygen saturation with supplemental oxygen measured?	○ Pulse Oximetry ○ Arterial blood gas measurement ○ Other ○ Unknown	FiO2 at time of lowest SpO2	_____ ○Fraction, 0.21-1.0 ○%, 21-100 ○Highest L/min		
Capillary refill time >2 seconds	○ Yes ○ No ○ Unknown	ACVPU	○ Alert ○ Confusion ○ Verbal ○ Pain ○ Unresponsive	Glasgow Coma Score (GCS / 15)	_____
Richmond Agitation-Sedation Scale (RASS)	_____	Urine output (mL/day)	_____		

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

Enter patient reported symptoms data for this date?	○ Yes ○ No	If Yes, complete the form:			
Fever	○ Yes ○ No ○ Unknown	Chills or rigors	○ Yes ○ No ○ Unknown	Fatigue / malaise / lethargy	○ Yes ○ No ○ Unknown

Weakness	○ Yes ○ No ○ Unknown	Muscle aches (myalgia)	○ Yes ○ No ○ Unknown	Skin rash	○ Yes ○ No ○ Unknown
Back Pain	○ Yes ○ No ○ Unknown			Neck Pain	○ Yes ○ No ○ Unknown
Cough	○ Yes ○ No ○ Unknown			If Yes: Cough type	○ Non Productive ○ Productive ○ Haemoptysis ○ Unknown
Shortness of breath	○ Yes ○ No ○ Unknown	Chest pain	○ Yes ○ No ○ Unknown	Abdominal pain	○ Yes ○ No ○ Unknown
Diarrhoea	○ Yes ○ No ○ Unknown	Vomiting	○ Yes ○ No ○ Unknown	Nausea	○ Yes ○ No ○ Unknown
Anorexia	○ Yes ○ No ○ Unknown	Urinary retention	○ Yes ○ No ○ Unknown	Increased urination (polyuria)	○ Yes ○ No ○ Unknown
Bleeding (haemorrhage)	○ Yes ○ No ○ Unknown			If Yes:	
Severe bleeding (requires intervention)	○ Yes ○ No ○ Unknown			Specify bleeding site(s)	☐ GI tract ☐ Gums ☐ Intra-articular ☐ Intracranial ☐ Intramuscular (with compartment syndrome) ☐ Intraocular ☐ Intraspinal ☐ Nose ☐ Pericardial ☐ Other _____
Headache	○ Yes ○ No ○ Unknown	Photophobia	○ Yes ○ No ○ Unknown	Seizures / convulsions	○ Yes ○ No ○ Unknown
Altered consciousness / confusion	○ Yes ○ No ○ Unknown				
Other symptom(s)	○ Yes ○ No ○ Unknown			If Yes:	_____

SIGNS: Record the clinical findings observed between 00:00 and 24:00 on the day of assessment			
Enter clinical signs data for this date?	○ Yes ○ No	If Yes:	
Hypothermia	○ Yes ○ No ○ Unknown	Cold / clammy peripheries	○ Yes ○ No ○ Unknown

Dehydration	○ Yes ○ No ○ Unknown		If Yes: Dehydration Status	○ Mild ○ Moderate ○ Severe	
Oedema	○ Yes ○ No ○ Unknown	Reduced urine output	○ Yes ○ No ○ Unknown	Respiratory distress	○ Yes ○ No ○ Unknown
Lower chest wall indrawing	○ Yes ○ No ○ Unknown	Fast breathing (tachypnoea)	○ Yes ○ No ○ Unknown	Rapid heart rate (tachycardia)	○ Yes ○ No ○ Unknown
Peripheral cyanosis	○ Yes ○ No ○ Unknown	Ascites	○ Yes ○ No ○ Unknown	Palpable liver/Hepatomegaly	○ Yes ○ No ○ Unknown
Palpable spleen/splenomegaly	○ Yes ○ No ○ Unknown	Tender abdomen	○ Yes ○ No ○ Unknown	Jaundice	○ Yes ○ No ○ Unknown
Anaemia	○ Yes ○ No ○ Unknown	Cognitive impairment	○ Yes ○ No ○ Unknown	Agitation	○ Yes ○ No ○ Unknown
Subconjunctival haemorrhage	○ Yes ○ No ○ Unknown				
Other sign(s)	○ Yes ○ No ○ Unknown		If Yes:	_____	

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

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

RESPIRATORY SUPPORT: Record all respiratory interventions given between 00:00 to 24:00 on day of assessment.					
Supplemental oxygen	○ Yes ○ No ○ Unknown		If Yes, complete the form:		
Nasal prongs	○ Yes ○ No ○ Unknown	Face mask	○ Yes ○ No ○ Unknown	High flow nasal oxygen	○ Yes ○ No ○ Unknown
Non-invasive ventilation	○ Yes ○ No ○ Unknown		If Yes: Type of non-invasive ventilation	○ CPAP ○ BIPAP ○ Unknown ○ Other	
Invasive ventilation	○ Yes ○ No ○ Unknown				
Extracorporeal life support therapy (ECLS) / Extracorporeal membrane oxygenation (ECMO)	○ Yes ○ No ○ Unknown		If Yes: Type of ECLS / ECMO	○ Veno-venous (VV) ○ Veno-arterial (VA) ○ Unknown	
Prone positioning	○ Yes ○ No ○ Unknown		If Yes: When was the prone positioning?	○ During invasive ventilation ○ Whilst self-ventilating ○ Unknown	
PaO2 sample type	○ Arterial ○ Capillary ○ Venous ○ Unknown ○ Not done		If Arterial, Capillary, Venous:		
PaO2	_____ ○kPa ○mmHg		FiO2 at time of PaO2	_____ ○Fraction, 0.21-1.0 ○%, 21-100	

ADVANCED CARE INTERVENTIONS: Record all advanced care interventions given between 00:00 to 24:00 on day of assessment.					
Were advanced care (including acute organ support and critical care) therapeutic interventions administered on this date?	○ Yes ○ No ○ Unknown		If Yes, complete the form:		
ICU / ITU / HDU / Intermediate Care Unit admission	○ Yes ○ No ○ Unknown	Neuromuscular blocking agents	○ Yes ○ No ○ Unknown	Inhaled nitric oxide	○ Yes ○ No ○ Unknown
Tracheostomy inserted	○ Yes ○ No ○ Unknown				
Renal replacement therapy (RRT) or dialysis / hemofiltration	○ Yes ○ No ○ Unknown		If Yes: Type of renal replacement therapy (RRT) or dialysis / hemofiltration		○ Intermittent ○ Continuous ○ Unknown
Any vasopressor / inotropic support	○ Yes ○ No ○ Unknown		If Yes:		

Reason for vasopressor / inotrope use	☐ Shock ☐ Persistent hypotension ☐ Other ☐ Unknown	Vasopressor / Inotropic support type	☐ Dopamine (<5ug/kg/min) ☐ Dopamine (5-15ug/kg/min) ☐ Dopamine (>15ug/kg/min) ☐ Norepinephrine (noradrenaline) < 0.1ug/kg/min ☐ Norepinephrine (noradrenaline) > 0.1ug/kg/min ☐ Epinephrine (adrenaline) ☐ Dobutamine ☐ Milrinone ☐ Levosimendan ☐ Vasopressin ☐ Phenylephrine ☐ Terlipressin ☐ Angiotensin-II
Other advanced care intervention(s) or procedure(s)	○ Yes ○ No ○ Unknown		

LABORATORY RESULTS: Record the value furthest from normal range between 00:00 to 24:00 on day of assessment.

Enter Laboratory Results data for this date?	○ Yes ○ No	If Yes, complete the form:			
Haemoglobin	_____ ○g/dL ○g/L	White blood cell (WBC) count (10^9/L)	_____	Neutrophils	_____ ○10^9/L ○%
Lymphocytes	_____ ○10^9/L ○%	Eosinophils	_____ ○10^9/L ○%	Haematocrit	_____ ○% ○L/L
Platelets	_____ ○10^9/L ○10^3/µL			Ery. mean corpuscular volume (MCV) (fL)	_____
Ery. mean corpuscular haemoglobin concentration	_____ ○g/L ○g/dL			Ery. mean corpuscular haemoglobin (MCH) (pg)	_____
Prothrombin Time (PT) (s)	_____			Activated Partial Thromboplastin Time (APTT) (s)	_____
Activated Partial Thromboplastin Time Ratio (APTR)	_____			International Normalized Ratio (INR)	_____
Alanine aminotransferase (ALT) / SGPT (U/L)	_____			Aspartate aminotransferase (AST) / SGOT (U/L)	_____
Alkaline phosphatase (ALP) / (IU/L)	_____			Gamma Glutamyl Transferase (GGT) (U/L)	_____
Random blood glucose	_____ ○mmol/L ○mg/dL ○g/L	Blood Urea Nitrogen	_____ ○mmol/L ○mg/dL	Creatinine	_____ ○µmol/L ○mg/dL
Sodium (mmol/L or mEq/L)	_____			Potassium (mmol/L or mEq/L)	_____
Lactate dehydrogenase (LDH) (U/L)	_____			Blood gas specimen type	○ Arterial ○ Capillary ○ Venous ○ Unknown

pH	_____	Bicarbonate (HCO3-) (mmol/L or mEq/L)	_____	Base Excess (mmol/L)	_____
Interleukin-6 (IL-6) (pg/mL or ng/L)	_____				

IMAGING

Enter Imaging data for this date?	○ Yes ○ No	If Yes, complete the form:	
Chest X-ray performed	○ Yes ○ No ○ Unknown	If Yes: Chest X-ray date	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]
Chest X-ray findings associated with this illness.	○ Normal or no acute change ○ Abnormal or acute change ○ Unknown		
New infiltrates present on X-ray	○ Yes, bilateral ○ Yes, unilateral ○ No ○ Unknown	If Yes: Infiltrates on X-ray consistent with	☐ Viral pneumonitis ☐ Bacterial pneumonia ☐ Pulmonary oedema ☐ Unknown
Pleural effusion on X-ray	○ Yes ○ No ○ Unknown	If Yes:	
Pleural effusion on X-ray details	○ Unilateral ○ Bilateral	Side(s) where pleural effusion identified	☐ Right ☐ Left
CT chest performed	○ Yes ○ No ○ Unknown		
CT chest findings associated with this illness	○ Normal or no acute change ○ Abnormal or acute change ○ Unknown		
New infiltrates present on CT	○ Yes, bilateral ○ Yes, unilateral ○ No ○ Unknown	If Yes: Infiltrates on CT chest consistent with	☐ Viral pneumonitis ☐ Bacterial pneumonia ☐ Pulmonary oedema ☐ Unknown
Pleural effusion on CT chest	○ Yes ○ No ○ Unknown	If Yes: Pleural effusion on CT chest details	○ Unilateral ○ Bilateral
Ultrasound performed	○ Yes ○ No ○ Unknown	If Yes:	
Ultrasound date	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]	Ultrasound region	○ Chest only ○ Abdomen only ○ Chest and abdomen ○ Cranial ○ Joints ○ Unknown
Ultrasound findings associated with this illness	○ Normal or no acute change ○ Abnormal or acute change ○ Unknown		

Ascites	○ Yes ○ No ○ Unknown	If Yes: Ascites grading	○ Small ○ Moderate ○ Severe
Consolidation	○ Yes ○ No ○ Unknown		
Pleural effusion	○ Yes ○ No ○ Unknown	If Yes:	
Pleural effusion right size (cm)	_____	Pleural effusion left size (cm)	_____
Pericardial effusion	○ Yes ○ No ○ Unknown	If Yes: Pericardial effusion size (cm)	_____
Liver size (cm)	_____	Gallbladder wall (mm)	_____
Electrocardiogram (ECG)	○ Yes-normal ○ Yes-abnormal ○ No ○ Unknown		
If Yes-abnormal: ECG summary	_____	If Yes: ECG date	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

RESEARCH SAMPLES

Was a biological sample taken for research on this day?	○ Yes ○ No	If Yes: If yes, please record the KIT number	_____

MEDICATION

MEDICATION: Complete one form for each medication prescribed from the day of presentation (the start of data capture) to the day of discharge.					
Type of agent	○ Antiviral ○ Corticosteroid ○ Analgesic ○ Antibiotic ○ Anticoagulant ○ Immunosuppressive drugs (non-steroid) ○ Inotropes / vasopressor ○ Intravenous immunoglobulin ○ Other ______________	○ Antiviral ○ Corticosteroid ○ Analgesic ○ Antibiotic ○ Anticoagulant ○ Immunosuppressive drugs (non-steroid) ○ Inotropes / vasopressor ○ Intravenous immunoglobulin ○ Other ______________	○ Antiviral ○ Corticosteroid ○ Analgesic ○ Antibiotic ○ Anticoagulant ○ Immunosuppressive drugs (non-steroid) ○ Inotropes / vasopressor ○ Intravenous immunoglobulin ○ Other ______________	○ Antiviral ○ Corticosteroid ○ Analgesic ○ Antibiotic ○ Anticoagulant ○ Immunosuppressive drugs (non-steroid) ○ Inotropes / vasopressor ○ Intravenous immunoglobulin ○ Other ______________	○ Antiviral ○ Corticosteroid ○ Analgesic ○ Antibiotic ○ Anticoagulant ○ Immunosuppressive drugs (non-steroid) ○ Inotropes / vasopressor ○ Intravenous immunoglobulin ○ Other ______________
Is this medication treating the disease?	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Medication Name					
Date medication started / first dose	[DD / MM / 20YY]	[DD / MM / 20YY]	[DD / MM / 20YY]	[DD / MM / 20YY]	[DD / MM / 20YY]
Date medication stopped / last dose	[DD / MM / 20YY]	[DD / MM / 20YY]	[DD / MM / 20YY]	[DD / MM / 20YY]	[DD / MM / 20YY]
Total number of days treatment given					
Medication route	○ Oral ○ Subcutaneous ○ Inhaled ○ IV ○ Topical ○ Unknown ○ Other ______________	○ Oral ○ Subcutaneous ○ Inhaled ○ IV ○ Topical ○ Unknown ○ Other ______________	○ Oral ○ Subcutaneous ○ Inhaled ○ IV ○ Topical ○ Unknown ○ Other ______________	○ Oral ○ Subcutaneous ○ Inhaled ○ IV ○ Topical ○ Unknown ○ Other ______________	○ Oral ○ Subcutaneous ○ Inhaled ○ IV ○ Topical ○ Unknown ○ Other ______________
Frequency					
Dose	______________ ↧mg ↧g ↧µg ↧IU ↧mg/kg ↧mg/day ↧mL ↧mL/h ↧% ↧tablets ↧Other ______________	______________ ↧mg ↧g ↧µg ↧IU ↧mg/kg ↧mg/day ↧mL ↧mL/h ↧% ↧tablets ↧Other ______________	______________ ↧mg ↧g ↧µg ↧IU ↧mg/kg ↧mg/day ↧mL ↧mL/h ↧% ↧tablets ↧Other ______________	______________ ↧mg ↧g ↧µg ↧IU ↧mg/kg ↧mg/day ↧mL ↧mL/h ↧% ↧tablets ↧Other ______________	______________ ↧mg ↧g ↧µg ↧IU ↧mg/kg ↧mg/day ↧mL ↧mL/h ↧% ↧tablets ↧Other ______________
Was this an off-label or compassionate use of the medication?	○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown

PATHOGEN TESTING

PATHOGEN TESTING: Results of all types of sample and pathogen testing (ONE FORM PER PATHOGEN)					
Collection date	[DD / MM / 20YY]	[DD / MM / 20YY]	[DD / MM / 20YY]	[DD / MM / 20YY]	[DD / MM / 20YY]
Biospecimen type	○ Whole blood ○ Serum ○ Plasma ○ Nasopharyngeal / respiratory swab ○ Urine ○ Other ___________	○ Whole blood ○ Serum ○ Plasma ○ Nasopharyngeal / respiratory swab ○ Urine ○ Other ___________	○ Whole blood ○ Serum ○ Plasma ○ Nasopharyngeal / respiratory swab ○ Urine ○ Other ___________	○ Whole blood ○ Serum ○ Plasma ○ Nasopharyngeal / respiratory swab ○ Urine ○ Other ___________	○ Whole blood ○ Serum ○ Plasma ○ Nasopharyngeal / respiratory swab ○ Urine ○ Other ___________
Pathogen tested / detected	○ Hantavirus ○ Leptospira spp. ○ Dengue virus ○ Influenza A ○ SARS-CoV-2 ○ Other ___________	○ Hantavirus ○ Leptospira spp. ○ Dengue virus ○ Influenza A ○ SARS-CoV-2 ○ Other ___________	○ Hantavirus ○ Leptospira spp. ○ Dengue virus ○ Influenza A ○ SARS-CoV-2 ○ Other ___________	○ Hantavirus ○ Leptospira spp. ○ Dengue virus ○ Influenza A ○ SARS-CoV-2 ○ Other ___________	○ Hantavirus ○ Leptospira spp. ○ Dengue virus ○ Influenza A ○ SARS-CoV-2 ○ Other ___________
Lab test method	○ PCR (NAAT) ○ Culture ○ RDT ○ ELISA ○ Other NAAT ○ Unknown	○ PCR (NAAT) ○ Culture ○ RDT ○ ELISA ○ Other NAAT ○ Unknown	○ PCR (NAAT) ○ Culture ○ RDT ○ ELISA ○ Other NAAT ○ Unknown	○ PCR (NAAT) ○ Culture ○ RDT ○ ELISA ○ Other NAAT ○ Unknown	○ PCR (NAAT) ○ Culture ○ RDT ○ ELISA ○ Other NAAT ○ Unknown
Lab marker	☐ NS1 Ag ☐ IgG ☐ IgM ☐ IgA ☐ Viral load / serotype (PCR/NAAT) ☐ Not applicable ☐ Unknown	☐ NS1 Ag ☐ IgG ☐ IgM ☐ IgA ☐ Viral load / serotype (PCR/NAAT) ☐ Not applicable ☐ Unknown	☐ NS1 Ag ☐ IgG ☐ IgM ☐ IgA ☐ Viral load / serotype (PCR/NAAT) ☐ Not applicable ☐ Unknown	☐ NS1 Ag ☐ IgG ☐ IgM ☐ IgA ☐ Viral load / serotype (PCR/NAAT) ☐ Not applicable ☐ Unknown	☐ NS1 Ag ☐ IgG ☐ IgM ☐ IgA ☐ Viral load / serotype (PCR/NAAT) ☐ Not applicable ☐ Unknown
Pathogen test result	○ Detected ○ Not detected ○ Equivocal ○ Unknown	○ Detected ○ Not detected ○ Equivocal ○ Unknown	○ Detected ○ Not detected ○ Equivocal ○ Unknown	○ Detected ○ Not detected ○ Equivocal ○ Unknown	○ Detected ○ Not detected ○ Equivocal ○ Unknown
Cycle threshold (CT) value					
Viral load (copies/mL)					
Genomic repository	○ EMBL - European Bioinformatics Institute(EBI) ○ Other ___________	○ EMBL - European Bioinformatics Institute(EBI) ○ Other ___________	○ EMBL - European Bioinformatics Institute(EBI) ○ Other ___________	○ EMBL - European Bioinformatics Institute(EBI) ○ Other ___________	○ EMBL - European Bioinformatics Institute(EBI) ○ Other ___________
Repository sequence identifier					

RESEARCH SAMPLES

RESEARCH SAMPLES			
If yes, please record the KIT number:	_____	Date sample obtained:	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

OUTCOME

COMPLICATIONS: Experienced at any time from day of presentation to day of discharge / outcome.					
Stroke / cerebrovascular accident	○ Yes ○ No ○ Unknown	Encephalopathy	○ Yes ○ No ○ Unknown	Seizure	○ Yes ○ No ○ Unknown
Encephalitis	○ Yes ○ No ○ Unknown	Meningitis	○ Yes ○ No ○ Unknown	Cardiac ischaemia	○ Yes ○ No ○ Unknown
Endocarditis	○ Yes ○ No ○ Unknown	Cardiomyopathy	○ Yes ○ No ○ Unknown	Congestive heart failure	○ Yes ○ No ○ Unknown
Cardiac arrhythmia	○ Yes ○ No ○ Unknown	Cardiac arrest	○ Yes ○ No ○ Unknown	Myocarditis	○ Yes ○ No ○ Unknown
Pericarditis	○ Yes ○ No ○ Unknown				
Pneumonia / pneumonitis	○ Yes ○ No ○ Unknown		If Yes: Etiology of pneumonia	○ Viral ○ Bacterial ○ Fungal	
Pneumothorax	○ Yes ○ No ○ Unknown	Pleural effusion	○ Yes ○ No ○ Unknown	Cryptogenic organising pneumonia (COP)	○ Yes ○ No ○ Unknown
Bronchiolitis	○ Yes ○ No ○ Unknown	Acute Respiratory Distress Syndrome (ARDS)	○ Yes ○ No ○ Unknown	Ascites	○ Yes ○ No ○ Unknown
Pancreatitis	○ Yes ○ No ○ Unknown	Jaundice	○ Yes ○ No ○ Unknown	Liver dysfunction	○ Yes ○ No ○ Unknown
Thromboembolism	○ Yes ○ No ○ Unknown		If Yes:		
Pulmonary embolism (PE)	○ Yes ○ No ○ Unknown		Deep vein thrombosis (DVT)	○ Yes ○ No ○ Unknown	
Severe bleeding (requiring intervention)	○ Yes ○ No ○ Unknown		If Yes: Severe bleeding site(s)	☐ Skin ☐ Petechiae ☐ Nose ☐ Gums ☐ GI tract ☐ Urinary tract ☐ Vagina ☐ Other(s) ☐ Unknown	
Anaemia	○ Yes ○ No ○ Unknown	Coagulation disorder / DIC	○ Yes ○ No ○ Unknown	Acute renal injury / acute renal failure	○ Yes ○ No ○ Unknown
Urinary tract infection	○ Yes ○ No ○ Unknown	Rhabdomyolysis	○ Yes ○ No ○ Unknown	Myositis	○ Yes ○ No ○ Unknown

Cellulitis	○ Yes ○ No ○ Unknown	Skin abscess	○ Yes ○ No ○ Unknown	Skin tissue loss or eschar	○ Yes ○ No ○ Unknown
Bacteraemia	○ Yes ○ No ○ Unknown	Hyperglycemia	○ Yes ○ No ○ Unknown	Hypoglycaemia	○ Yes ○ No ○ Unknown
Shock	○ Yes ○ No ○ Unknown				
Re-shock episodes	○ Yes ○ No ○ Unknown		If Yes: Number of re-shock episodes	○ 1 ○ 2 ○ 3 ○ 4+ ○ Unknown	
Sepsis	○ Yes ○ No ○ Unknown		Hypothermia	○ Yes ○ No ○ Unknown	
Other complication(s)	○ Yes ○ No ○ Unknown		If Yes:	_____	

DIAGNOSIS

Primary diagnosis	○ Andes virus infection (hantavirus) ○ Other _____	Type of diagnosis	☐ Clinical diagnosis ☐ Lab-confirmed ☐ Radiologically confirmed (e.g., chest X-ray, CT) ☐ Unknown ☐ Other	Secondary diagnosis	○ Other _____
Type of diagnosis	☐ Clinical diagnosis ☐ Lab-confirmed ☐ Radiologically confirmed (e.g., chest X-ray, CT) ☐ Unknown ☐ Other				

OUTCOME

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

If discharged alive or still hospitalised: Ongoing health care needs relating to this admission for pathogen of interest	○ Yes ○ No ○ Unknown	If discharged alive or still hospitalised: Ongoing health care needs NOT related to pathogen episode	○ Yes ○ No ○ Unknown
If Still hospitalised or transfer to other facility: Medically fit for discharge (pathogen resolved) but remains in hospital for other reason (e.g. awaiting alternate care, resident in long term health care or mental health facility)	○ Yes ○ No ○ Unknown		
If transfer to other facility: is the transfer facility a study site?	○ Yes ○ No ○ Unknown	If Yes: What is the Participant Identification Number at the new facility?	_____

WITHDRAWAL

WITHDRAWAL			
Date of withdrawal	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]	Reason for withdrawal	_____
Did the participant withdraw from active participation in the study?	○ Yes ○ No ○ Unknown	Did the participant withdraw consent to use data collected up until the point of withdrawal?	○ Yes ○ No ○ Unknown
Did the participant withdraw consent to use samples collected up until the point of withdrawal?	○ Yes ○ No ○ Unknown		