IPRO

SARS-COV2 (COVID-19) Testing Results

Test 1

COVID-19 Test	Collection Date (mm/dd/yyyy)	Result Date (mm/dd/yyyy)	Testing Facility PFI	Other Facility PFI	Test Result
○ Molecular Assay (PCR, NAA)					○ Positive/ Presumptive Positive
○ Serology					○ Negative
○ Method unknown					○ Indeterminate
○ Other, Specify					○ ND

Test 2

COVID-19 Test	Collection Date (mm/dd/yyyy)	Result Date (mm/dd/yyyy)	Testing Facility PFI	Other Facility PFI	Test Result
○ Molecular Assay (PCR, NAA)					○ Positive/ Presumptive Positive
○ Serology					○ Negative
○ Method unknown					○ Indeterminate
○ Other, Specify					○ ND

Test 3

COVID-19 Test	Collection Date (mm/dd/yyyy)	Result Date (mm/dd/yyyy)	Testing Facility PFI	Other Facility PFI	Test Result
○ Molecular Assay (PCR, NAA)					○ Positive/ Presumptive Positive
○ Serology					○ Negative
○ Method unknown					○ Indeterminate
○ Other, Specify					○ ND

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SARS-COV2 (COVID-19) Testing Results

Test 4

COVID-19 Test	Collection Date (mm/dd/yyyy)	Result Date (mm/dd/yyyy)	Testing Facility PFI	Other Facility PFI	Test Result
○ Molecular Assay (PCR, NAA)					○ Positive/ Presumptive Positive
○ Serology					○ Negative
○ Method unknown					○ Indeterminate
○ Other, Specify					○ ND

Test 5

COVID-19 Test	Collection Date (mm/dd/yyyy)	Result Date (mm/dd/yyyy)	Testing Facility PFI	Other Facility PFI	Test Result
○ Molecular Assay (PCR, NAA)					○ Positive/ Presumptive Positive
○ Serology					○ Negative
○ Method unknown					○ Indeterminate
○ Other, Specify					○ ND

Test 6

COVID-19 Test	Collection Date (mm/dd/yyyy)	Result Date (mm/dd/yyyy)	Testing Facility PFI	Other Facility PFI	Test Result
○ Molecular Assay (PCR, NAA)					○ Positive/ Presumptive Positive
○ Serology					○ Negative
○ Method unknown					○ Indeterminate
○ Other, Specify					○ ND

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SARS-COV2 (COVID-19) - ICU and Other Interventions

1. Admissions to ICU

1a. Was the patient admitted to an intensive care unit (ICU)? ○ Yes ○ No ○ Unknown

Date of ICU Admission	Unknown Date of ICU Admission	Date of ICU Discharge	Unknown Date of ICU Discharge
	○ Yes		○ Yes

1b. Was the patient admitted ICU a second time? ○ Yes ○ No ○ Unknown

Date of ICU Admission	Unknown Date of ICU Admission	Date of ICU Discharge	Unknown Date of ICU Discharge
	○ Yes		○ Yes

1c. Was the patient admitted ICU a third time? ○ Yes ○ No ○ Unknown

Date of ICU Admission	Unknown Date of ICU Admission	Date of ICU Discharge	Unknown Date of ICU Discharge
	○ Yes		○ Yes

				Start Date	Unknown Start Date	Stop Date	Unknown Stop Date
2. BIPAP or CPAP use?	○ Yes	○ No	○ Unknown		○		○
2a.Nasal cannula (not high flow)	○ Yes	○ No	○ Unknown		○		○
3. High flow nasal cannula (e.g. ,Vapotherm)	○ Yes	○ No	○ Unknown		○		○
4. Invasive mechanical ventilation?	○ Yes	○ No	○ Unknown		○		○
5. ECMO	○ Yes	○ No	○ Unknown		○		○
6.Vasopressor use?	○ Yes	○ No	○ Unknown		○		○
7. Systemic steroids	○ Yes	○ No	○ Unknown		○		○

Sequential organ failure assessment score (SOFA) ☐☐☐☐ SOFA Date: ☐☐☐☐☐☐☐☐

COVID-19 - ICU, Other Interventions, Outcome

Outcome

1. What was the outcome of the patient upon discharge?
   - ○ Alive
   - ○ Died during hospitalization
   - ○ Unknown

2. Date of Death

Cause of Death (open text)

Cause of death (ICD-10 codes)

3. If patient discharged alive, please indicate to where:
   - ○ Private residence
   - ○ Home with services
   - ○ Hospice
   - ○ Facility
   - ○ Homeless/shelter
   - ○ Corrections facility
   - ○ Leave against medical advice
   - ○ Discharged to another facility
   - ○ Other, specify
   - ○ Unknown

Admission Signs and Patient History

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1. **Acute signs/symptoms present at admission**

○ None of the below signs/symptoms

Non-respiratory symptoms

- ☐ Abdominal pain
- ☐ Altered mental status/ confusion
- ☐ Chest pain
- ☐ Conjunctivitis
- ☐ Diarrhea
- ☐ Fever/ chills
- ☐ Headache
- ☐ Muscle aches/ myalgia
- ☐ Nausea/ vomiting
- ☐ Rash
- ☐ Seizures
- ☐ Loss of taste
- ☐ Loss of smell

Respiratory symptoms

- ☐ Congested/ runny nose
- ☐ Cough
- ☐ Hemoptysis/ Bloody sputum
- ☐ Shortness of breath/ Respiratory distress
- ☐ Sore throat
- ☐ URI/ ILI
- ☐ Wheezing

For cases < 2 years

- ☐ Apnea
- ☐ Cyanosis
- ☐ Decreased vocalization/ stridor
- ☐ Dehydration
- ☐ Hypothermia
- ☐ Inability to eat/ poor feeding
- ☐ Lethargy

2. **Date of onset of acute respiratory symptoms** ☐☐/☐☐/☐☐☐☐ ○ Unknown ○ Not Applicable

3. **Height** ☐☐☐☐ ○ Inch ○ cm ○ Unknown

4. **Weight** ☐☐☐☐ ○ lbs ○ kg ○ Unknown

5. **BMI** ☐☐☐☐ ○ Unknown **Obese:** ○ Yes ○ No ○ Unknown

BMI Final ☐☐☐☐ ○ Unknown

6. **Smoker (tobacco)** ○ Current ○ Former ○ No ○ Unknown

7. **Vaping** ○ Current ○ Former ○ No ○ Unknown

8. **Alcohol abuse** ○ Current ○ Former ○ No ○ Unknown

Please print carefully and avoid contact with the edges of the box.

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First Vital Signs and First Lab Values

1. Heart rate (beats/ min)					○ Unknown
2. Respiratory rate (breaths/min)					○ Unknown
3. Systolic blood pressure (mmhg)					○ Unknown
4. Diastolic blood pressure (mmhg)					○ Unknown
5. Temperature		○ °C ○ °F			○ Unknown
6a. O2 Saturation		%			○ Unknown
6b. Type of support when O2 saturation was measured	○ Room air	○ Face mask	○ Other, specify		
	○ Invasive mechanical ventilation	○ CPAP or BIPAP			
	○ Nasal cannula	○ High flow nasal cannula	○ Unknown		
6c. Fraction of inspired Oxygen/ flow		○ %L	○ Liters/ minute (LPM)	○ Unknown	○ N/A
7. Glasgow coma scale (GCS)				○ Unknown	○ N/A
8. White blood cell count		○ Cells x 10^9/L	○ x 1000/uL	○ Other:	○ N/A
9. Hematocrit (HCT)		%			○ NA
10. Platelets (Plt)		○ Cells x 10^9/L	○ x 1000/uL	○ Other:	○ NA
11. Sodium (Na)		○ mmol/L	○ mEq/L	○ Other:	○ NA
12. Blood urea nitrogen (BUN)		○ mg/dl		○ Other:	○ NA
13. Creatinine (Cr)		○ mg/dl		○ Other:	○ NA
14. Glucose		○ mg/dl		○ Other:	○ NA
15. Aspartate transaminase (AST)		○ U/L	○ IU/L	○ Other:	○ NA
16. Alanine aminotransferase (ALT)		○ U/L	○ IU/L	○ Other:	○ NA
17. Arterial pH					○ NA

First Vital Signs and First Lab Values

18. LDH	☐☐☐☐	U/L	○ Unknown
19. CRP	☐☐☐☐	mg/L	○ Unknown
20. Ferritin	☐☐☐☐	ng/mL	○ Unknown
21. D-dimer	☐☐☐☐	ng/mL	○ Unknown
22. IL-6	☐☐☐☐	pg/mL	○ Unknown
23. (PCT) Pro-calcitonin	☐☐☐☐	ng/mL	○ Unknown
24. ESR	☐☐☐☐	mm/hr	○ Unknown
25. Fibrinogen	☐☐☐☐	mg/dL	○ Unknown

☐☐☐☐☐☐☐☐☐☐☐☐

Underlying Medical Conditions

1. **Did the patient have any pre-existing medical conditions?** ○ Yes ○ No ○ Unknown

1a. Chronic lung disease ○ Yes ○ No ○ Unknown

Chronic lung disease underlying conditions

- ☐ Active Tuberculosis (TB)
- ☐ Asbestosis
- ☐ Asthma/Reactive airway disease
- ☐ Bronchiectasis
- ☐ Bronchiolitis obliterans
- ☐ Chronic bronchitis
- ☐ Chronic respiratory failure
- ☐ Cystic Fibrosis (CF)
- ☐ Emphysema/Chronic obstructive pulmonary disease (COPD)
- ☐ Interstitial lung disease (ILD)
- ☐ Obstructive sleep apnea (OSA)
- ☐ Oxygen (O_2) dependent
- ☐ Pulmonary fibrosis
- ☐ Restrictive lung disease
- ☐ Sarcoidosis

1b.Chronic metabolic disease ○ Yes ○ No ○ Unknown

Chronic metabolic disease underlying conditions

- ☐ Adrenal Disorders
- ☐ Diabetes mellitus (DM)
- ☐ Glycogen or other storage diseases
- ☐ Hyper/Hypo- function of pituitary gland
- ☐ Inborn errors of metabolism
- ☐ Metabolic syndrome
- ☐ Parathyroid dysfunction
- ☐ Thyroid dysfunction

1c.Blood disorders/ hemoglobinopathy ○ Yes ○ No ○ Unknown

Blood disorders/ hemoglobinopathy underlying conditions

- ☐ Alpha thalassemia
- ☐ Aplastic anemia
- ☐ Beta thalassemia
- ☐ Coagulopathy
- ☐ Hemoglobin S-beta thalassemia
- ☐ Leukopenia
- ☐ Myelodysplastic syndrome (MDS)
- ☐ Neutropenia
- ☐ Pancytopenia
- ☐ Polycythemia vera
- ☐ Sickle cell disease
- ☐ Splenectomy/Asplenia
- ☐ Thrombocytopenia

Please print carefully and avoid contact with the edges of the box.

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Underlying Medical Conditions (Continued)

1d. Cardiovascular disease

○ Yes ○ No ○ Unknown

Cardiovascular disease underlying conditions

- ☐ Aortic aneurysm (AAA), history of
- ☐ Aortic/Mitral/Tricuspid/Pulmonic valve replacement
- ☐ Aortic regurgitation (AR)
- ☐ Aortic stenosis (AS)
- ☐ Atherosclerotic cardiovascular disease (ASCVD)
- ☐ Atrial fibrillation (AFib)
- ☐ Atrioventricular (AV) blocks
- ☐ Automated implantable devices (AID/AICD) / Pacemaker
- ☐ Bundle branch block (BBB, LBBB, RBBB)
- ☐ Cardiomyopathy
- ☐ Carotid stenosis
- ☐ Cerebral vascular accident (CVA)/ incident/ stroke, history of
- ☐ Congenital heart disease, (Specify below)
  - ☐ Atrial septal defect
  - ☐ Pulmonic stenosis
  - ☐ Tetralogy of Fallot
  - ☐ Ventricular septal defect
  - ☐ Other, specify
- ☐ Coronary artery bypass grafting (CABG), history of
- ☐ Coronary artery disease (CAD)
- ☐ Deep vein thrombosis (DVT), history of
- ☐ Heart failure/Congestive heart failure (CHF)
- ☐ Myocardial infarction (MI), history of
- ☐ Mitral regurgitation (MR)
- ☐ Mitral stenosis (MS)
- ☐ Peripheral artery disease (PAD)
- ☐ Peripheral vascular disease (PVD)
- ☐ Pulmonary embolism (PE)
- ☐ Pulmonary hypertension (PHTN), history of
- ☐ Pulmonic regurgitation
- ☐ Pulmonic stenosis
- ☐ Transient ischemic attack (TIA), history of
- ☐ Tricuspid regurgitation (TR)
- ☐ Tricuspid stenosis
- ☐ Ventricular fibrillation (VF, VFib), history of
- ☐ Ventricular tachycardia (VT, VTach), history of

Please print carefully and avoid contact with the edges of the box.

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Underlying Medical Conditions (Continued)

1e.Neurologic disorders ○ Yes ○ No ○ Unknown

Neurologic conditions

- ☐ Amyotrophic lateral sclerosis (ALS)
- ☐ Cerebral palsy
- ☐ Cognitive dysfunction
- ☐ Dementia/ Alzheimer's disease
- ☐ Developmental delay
- ☐ Down Syndrome/ Trisomy 21
- ☐ Edward's syndrome/ Trisomy 18
- ☐ Epilepsy/ Seizure/ Seizure disorder
- ☐ Mitochondrial disorder
- ☐ Multiple sclerosis (MS)
- ☐ Muscular dystrophy
- ☐ Myasthenia gravis (MG)
- ☐ Neural tube defects/ Spina bifida
- ☐ Neuropathy
- ☐ Parkinson's disease
- ☐ Plegias/ Paralysis/ Quadriplegia
- ☐ Scoliosis/ Kyphoscoliosis
- ☐ Traumatic brain injury (TBI), history of

1f.History of Guillain-Barre Syndrome ○ Yes ○ No ○ Unknown

1g.Immunocompromised condition ○ Yes ○ No ○ Unknown

Immunocompromised underlying conditions

- ☐ AIDS or CD4 count < 200
- ☐ Complement deficiency
- ☐ Grafts-Vs-Host disease (GVHD)
- ☐ HIV infection
- ☐ Immunoglobulin deficiency/ Immunodeficiency
- ☐ Immunosuppressive therapy
  Specify condition:
- ☐ Leukemia*
- ☐ Lymphoma/ Hodgkins/ Non-Hodgkins (NHL)*
- ☐ Metastatic cancer*
- ☐ Multiple Myeloma*
- ☐ Solid organ malignancy
  Specify organ:
- ☐ Steroid therapy
- ☐ Transplant, hematopoietic stem cell (bone marrow transplant (BMT), Peripheral stem cell transplant (PSCT))
- ☐ Transplant, solid organ (SOT), history of

1h.Renal disease ○ Yes ○ No ○ Unknown

Renal disease underlying conditions

- ☐ Chronic kidney disease (CKD)/ Chronic renal insufficiency (CRI)
- ☐ Dialysis (HD)
- ☐ End stage renal disease (ESRD)
- ☐ Glomerulonephritis (GN)
- ☐ Nephrotic syndrome
- ☐ Polycystic kidney disease (PCKD)

Please print carefully and avoid contact with the edges of the box.

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Underlying Medical Conditions (Continued)

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1i. Gastrointestinal/ liver disease ○ Yes ○ No ○ Unknown

Gastrointestinal/ liver disease underlying conditions

- ☐ Alcoholic hepatitis
- ☐ Autoimmune hepatitis
- ☐ Barrett's esophagitis
- ☐ Chronic liver disease
- ☐ Chronic pancreatitis
- ☐ Cirrhosis/ End stage liver disease (ESLD)
- ☐ Crohn's disease
- ☐ Esophageal varices
- ☐ Esophageal strictures
- ☐ Hepatitis B, chronic (HBV)
- ☐ Hepatitis C, chronic (HCV)
- ☐ Non-alcoholic fatty liver disease (NAFLD)/NASH
- ☐ Ulcerative colitis (UC)

1j.Rheumatologic/ autoimmune/ inflammatory condition ○ Yes ○ No ○ Unknown

Rheumatologic/ autoimmune/ inflammatory underlying conditions

- ☐ Ankylosing spondylitis
- ☐ Dermatomyositis
- ☐ Juvenile idiopathic arthritis
- ☐ Kawasaki disease
- ☐ Microscopic polyangiitis
- ☐ Polyarteritis nodosum (PAN)
- ☐ Polymyalgia rheumatica
- ☐ Polymyositis
- ☐ Psoriatic arthritis
- ☐ Rheumatoid arthritis (RA)
- ☐ Systemic lupus erythematosus (SLE)/ Lupus
- ☐ Systemic sclerosis
- ☐ Takayasu arteritis
- ☐ Temporal/ Giant cell arteritis
- ☐ Vasculitis, other

1k.Other ○ Yes ○ No ○ Unknown

Other underlying conditions

- ☐ Hypertension
- ☐ Post-partum
- ☐ Feeding tube dependent
- ☐ Trach dependent/ Vent dependent
- ☐ Wheelchair dependent
- ☐ Other

1l.Pediatric case only ○ Yes ○ No ○ Unknown

Pediatric cases only - underlying conditions

- ☐ Abnormality of airway
- ☐ Chronic lung disease of prematurity/ Bronchopulmonary dysplasia (BPD)
- ☐ History of febrile seizures
- ☐ Long term aspirin therapy
- ☐ Premature

Specify gestational age at birth in weeks: ☐☐☐☐ ○ Unknown

Please print carefully and avoid contact with the edges of the box.

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Bacterial Pathogens (sterile or respiratory site only)

1. Were any bacterial culture tests performed with a collection date within 7 days of admission, or if deceased, within 3 days prior to death or 24 hours after death? ○ Yes ○ No ○ Unknown

2. If yes, was there a positive culture for a bacterial pathogen? ○ Yes ○ No ○ Unknown

In order to ensure that the collection site is connected to the pathogen, each column/date on this form should ONLY be used for one pathogen.

Collect info on up to 5 pathogens (rather than 5 collection dates).

	Date (mm/dd/yyyy)	Date (mm/dd/yyyy)	Date (mm/dd/yyyy)	Date (mm/dd/yyyy)	Date (mm/dd/yyyy)
Acinetobacter baumannii	☐	☐	☐	☐	☐
Acinetobacter species	☐	☐	☐	☐	☐
Enterobacter aerogenes	☐	☐	☐	☐	☐
Enterobacter cloacae	☐	☐	☐	☐	☐
Enterobacter species	☐	☐	☐	☐	☐
Enterococcus faecium	☐	☐	☐	☐	☐
Enterococcus faecalis	☐	☐	☐	☐	☐
Enterococcus species	☐	☐	☐	☐	☐
Escherichia coli	☐	☐	☐	☐	☐
Haemophilus influenzae	☐	☐	☐	☐	☐
Klebsiella oxtoca	☐	☐	☐	☐	☐
Klebsiella pneumoniae	☐	☐	☐	☐	☐
Klebsiella Species	☐	☐	☐	☐	☐
Listeria monocytogenes	☐	☐	☐	☐	☐
Legionella	☐	☐	☐	☐	☐
Neisseria meningitides	☐	☐	☐	☐	☐
Proteus mirabilis	☐	☐	☐	☐	☐
Pseudomonas aeruginosa	☐	☐	☐	☐	☐
Serratia marcescens	☐	☐	☐	☐	☐
Staphylococcus aureus,	☐	☐	☐	☐	☐
specify: Methicillin resistant (1)	○	○	○	○	○
Methicillin sensitive (2)	○	○	○	○	○
Sensitivity unknown (3)	○	○	○	○	○

Bacterial Pathogens (sterile or respiratory site only)

	Date (mm/dd/yyyy)	Date (mm/dd/yyyy)	Date (mm/dd/yyyy)	Date (mm/dd/yyyy)	Date (mm/dd/yyyy)
Group A Streptococcus	☐	☐	☐	☐	☐
Group B Streptococcus	☐	☐	☐	☐	☐
Streptococcus agalactiae	☐	☐	☐	☐	☐
Streptococcus pneumoniae	☐	☐	☐	☐	☐
Streptococcus pyogenes	☐	☐	☐	☐	☐
Streptococcus viridans	☐	☐	☐	☐	☐
Other, specify	☐	☐	☐	☐	☐
Site where pathogen identified					
Blood	☐	☐	☐	☐	☐
Bronchoalveolar lavage	☐	☐	☐	☐	☐
Pleural fluid	☐	☐	☐	☐	☐
Cerebrospinal fluid	☐	☐	☐	☐	☐
Sputum	☐	☐	☐	☐	☐
Endotracheal aspirate	☐	☐	☐	☐	☐
Other, specify	☐	☐	☐	☐	☐

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Viral Pathogen

1. Was patient tested for any viral pathogens within 14 days prior to or within 7 days after admission, or if deceased, 14 days prior to death or 24 hours after death? ○ Yes ○ No ○ Unknown

	Type	Date			
1a. RSV			○ Yes, positive	○ Yes, Negative	○ Not tested/Unknown
1b.Influenza A	○ H1N1-2009 ○ H3N2 ○ Other, please specify ○ Unknown		○ Yes, positive	○ Yes, Negative	○ Not tested/Unknown
1c.Influenza B	○ Victoria ○ Yamagata ○ Other, please specify ○ Unknown		○ Yes, positive	○ Yes, Negative	○ Not Tested/Unknown
1d. Flu (not subtyped) result			○ Yes, positive	○ Yes, Negative	○ Not Tested/Unknown
1e. Adenovirus result			○ Yes, positive	○ Yes, Negative	○ Not Tested/Unknown
1f. Parainfluenza 1 result			○ Yes, positive	○ Yes, Negative	○ Not Tested/Unknown
1g. Parainfluenza 2 result			○ Yes, positive	○ Yes, Negative	○ Not Tested/Unknown
1h. Parainfluenza 3 result			○ Yes, positive	○ Yes, Negative	○ Not Tested/Unknown
1i. Parainfluenza 4 result			○ Yes, positive	○ Yes, Negative	○ Not Tested/Unknown
1j. Human metapneumovirus (HMPV) result			○ Yes, positive	○ Yes, Negative	○ Not Tested/Unknown
1k. Rhinovirus/ enterovirus result			○ Yes, positive	○ Yes, Negative	○ Not Tested/Unknown
1l. Coronavirus 229E result			○ Yes, positive	○ Yes, Negative	○ Not Tested/Unknown
1m. Coronavirus HKU1 result			○ Yes, positive	○ Yes, Negative	○ Not Tested/Unknown
1n. Coronavirus NL63 result			○ Yes, positive	○ Yes, Negative	○ Not Tested/Unknown
1o. Coronavirus OC43 result			○ Yes, positive	○ Yes, Negative	○ Not Tested/Unknown
1p. Coronavirus (unsubtyped) result			○ Yes, positive	○ Yes, Negative	○ Not Tested/Unknown

COVID-19 Treatment

1. Did the patient receive hydroxychloroquine, chloroquine or azithromycin treatments during the course of this illness

○ Yes ○ No ○ Unknown

1a. Did patient receive hydroxychloriquine (*Plaquenil, Quineprox*)?

○ Yes ○ No ○ Unknown

hydroxychloroquine

Start Date [ ] ○ Unknown

Stop Date [ ] ○ Unknown

Method of administration: ○ Oral (po) ○ Intravenous (IV) ○ Inhaled ○ Unknown

Dosage: ○ 200mg ○ 100mg ○ Other, specify [ ] ○ Unknown

Frequency: ○ QD ○ BID ○ TID ○ QOD ○ Other, specify [ ] ○ Unknown

hydroxychloroquine

Start Date [ ] ○ Unknown

Stop Date [ ] ○ Unknown

Method of administration: ○ Oral (po) ○ Intravenous (IV) ○ Inhaled ○ Unknown

Dosage: ○ 200mg ○ 100mg ○ Other, specify [ ] ○ Unknown

Frequency: ○ QD ○ BID ○ TID ○ QOD ○ Other, specify [ ] ○ Unknown

hydroxychloroquine

Start Date [ ] ○ Unknown

Stop Date [ ] ○ Unknown

Method of administration: ○ Oral (po) ○ Intravenous (IV) ○ Inhaled ○ Unknown

Dosage: ○ 200mg ○ 100mg ○ Other, specify [ ] ○ Unknown

Frequency: ○ QD ○ BID ○ TID ○ QOD ○ Other, specify [ ] ○ Unknown

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COVID-19 Treatment

1b. Did patient receive Chloroquine *(Aralen, Aralen Phosphate, Aralen Hydrochloride) ?* ○ Yes ○ No ○ Unknown

Chloroquine

Start Date: ____ ○ Unknown

Stop Date: ____ ○ Unknown

Method of administration: ○ Oral (po) ○ Intravenous (IV) ○ Inhaled ○ Unknown

Dosage: ○ 200mg ○ 100mg ○ Other, specify ____ ○ Unknown

Frequency: ○ QD ○ BID ○ TID ○ QOD ○ Other, specify ____ ○ Unknown

Chloroquine

Start Date: ____ ○ Unknown

Stop Date: ____ ○ Unknown

Method of administration: ○ Oral (po) ○ Intravenous (IV) ○ Inhaled ○ Unknown

Dosage: ○ 200mg ○ 100mg ○ Other, specify ____ ○ Unknown

Frequency: ○ QD ○ BID ○ TID ○ QOD ○ Other, specify ____ ○ Unknown

Chloroquine

Start Date: ____ ○ Unknown

Stop Date: ____ ○ Unknown

Method of administration: ○ Oral (po) ○ Intravenous (IV) ○ Inhaled ○ Unknown

Dosage: ○ 200mg ○ 100mg ○ Other, specify ____ ○ Unknown

Frequency: ○ QD ○ BID ○ TID ○ QOD ○ Other, specify ____ ○ Unknown

COVID-19 Treatment

1c. Did patient receive Azithromycin (*Zithromax, Azithromycin Dose Pakc, Z-Pack, Zmax)* ? ◯ Yes ◯ No ◯ Unknown

Azithromycin

Start Date	Stop Date	Method of administration	Dosage	Frequency
☐	☐	◯ Oral (po)	◯ 200mg	◯ QD
◯ Unknown	◯ Unknown	◯ Intravenous (IV)	◯ 100mg	◯ BID
		◯ Inhaled	◯ Other, specify ☐	◯ TID
		◯ Unknown	◯ Unknown	◯ QOD
				◯ Other, specify ☐
				◯ Unknown

Azithromycin

Start Date	Stop Date	Method of administration	Dosage	Frequency
☐	☐	◯ Oral (po)	◯ 200mg	◯ QD
◯ Unknown	◯ Unknown	◯ Intravenous (IV)	◯ 100mg	◯ BID
		◯ Inhaled	◯ Other, specify ☐	◯ TID
		◯ Unknown	◯ Unknown	◯ QOD
				◯ Other, specify ☐
				◯ Unknown

Azithromycin

Start Date	Stop Date	Method of administration	Dosage	Frequency
☐	☐	◯ Oral (po)	◯ 200mg	◯ QD
◯ Unknown	◯ Unknown	◯ Intravenous (IV)	◯ 100mg	◯ BID
		◯ Inhaled	◯ Other, specify ☐	◯ TID
		◯ Unknown	◯ Unknown	◯ QOD
				◯ Other, specify ☐
				◯ Unknown

COVID-19 Treatment

Erythromycin: Erythrocin, EryPed, Ery-Tab, E-Mycin	Yes	No	Unknown
Clarithromycin: Biaxin, Biaxin XL	Yes	No	Unknown

Other Angiotensin Receptor Blockers

Losartan (Cozaar)	Yes	No	Unknown
ATACAND (candesartan)	Yes	No	Unknown
Avapro (irbesartan)	Yes	No	Unknown
Benicar (Olmesartan)	Yes	No	Unknown
Diovan (valsartan)	Yes	No	Unknown
Micardis (telmisartan)	Yes	No	Unknown
Teveten (eprosartan)	Yes	No	Unknown
Prexartan (valsartan)	Yes	No	Unknown
Edarbi (azilsartan medoxomil)	Yes	No	Unknown

ACE inhibitors

Benazepril (Lotensin)	Yes	No	Unknown
Captopril (Capoten)	Yes	No	Unknown
Enalapril/Enalaprilat (Vasotec oral and injectable)	Yes	No	Unknown
Fosinopril (Monopril)	Yes	No	Unknown
Lisinopril (Zestril and Prinivil)	Yes	No	Unknown
Moexipril (Univasc)	Yes	No	Unknown
Perindopril (Aceon)	Yes	No	Unknown
Quinapril (Accupril)	Yes	No	Unknown
Ramipril (Altace)	Yes	No	Unknown
Trandolapril (Mavik)	Yes	No	Unknown

COVID-19 Treatment

NSAIDS:

Aspirin	Yes	No	Unknown
Celecoxib (Celebrex)	Yes	No	Unknown
Diclofenac (Cambia, Cataflam, Voltaren-XR, Zipsor, Zorvolex)	Yes	No	Unknown
Ibuprofen (Motrin, Advil)	Yes	No	Unknown
Indomethacin (Indocin)	Yes	No	Unknown
Naproxen (Aleve, Anaprox, Naprelan, Naprosyn)	Yes	No	Unknown
Oxaprozin (Daypro)	Yes	No	Unknown
Piroxicam (Feldene)	Yes	No	Unknown

COVID-19 Chest Imaging, Pregnancy, Adverse Effect of Medication

IPRO

Chest Imaging

1. Was a chest x-ray taken during hospitalization? ○ Yes ○ No ○ Unknown

2. Were any of these chest x-rays abnormal? ○ Yes ○ No ○ Unknown

2a. Date of first abnormal chest x-ray

2b. For the first abnormal chest x-ray, please check all that apply

- ☐ Report not available
- ☐ Air space density
- ☐ Air space opacity
- ☐ Bronchopneumonia/ pneumonia
- ☐ Cannot rule out pneumonia
- ☐ Consolidation
- ☐ Cavitation
- ☐ ARDS (Acute Respiratory Distress Syndrome)
- ☐ Lung infiltrate
- ☐ Interstitial infiltrate
- ☐ Lobar (NOT interstitial) infiltrate
- ☐ Pleural Effusion
- ☐ Empyema
- ☐ Other

3. Was a chest CT/ MRI taken during hospitalization? ○ Yes ○ No ○ Unknown

4. Were any of these chest CT/ MRIs abnormal? ○ Yes ○ No ○ Unknown

4a. Date of first abnormal CT/MRI

Chest Imaging, Pregnancy and Adverse Effect of Medication

Pregnancy

1. Specify gestational age in weeks		○ Unknown	
2. Indicate pregnancy status at discharge or death	○ Still pregant	○ No longer pregnant	○ Unknown

Adverse Effect of Medication

1. Diarrhea at any time during hospital stay?	○ Yes	○ No	○ Unknown
2. Hypoglycemia at any time during hospital stay?	○ Yes	○ No	○ Unknown
3. Was EKG performed at any time during hospital stay?	○ Yes	○ No	○ Unknown
4. QT Prolongation on EKG at any time during hospital stay?	○ Yes	○ No	○ Unknown
5. Cardiac arrest at any time during hospital stay?	○ Yes	○ No	○ Unknown
6. Arrhythmia at any time during hospital stay	○ Yes	○ No	○ Unknown

17000

COVID-19 Study - Patient Demographic and Enrollment

IPRO

Patient Last Name

Patient First Name **MI**

Medical Record Number

Medicaid Number

Date of Birth (mm/dd/yyyy)

Patient Address Type

- ○ Residential
- ○ Post Office Box
- ○ Long-Term Care Facility
- ○ Corrections
- ○ Military
- ○ Homeless
- ○ Other (Assign this value for cases with a known address that does not conform to the above categories)
- ○ Insufficient (Assign this value if the address could not be successfully geocoded)
- ○ Missing- Assign this value if no address information is present (e.g. only county or zip code)

Patient Zip Code

Sex at Birth

- ○ Male
- ○ Female

Hospital where patient treated

Name:

PFI:

Admission Date:

Discharge Date:

Specify other hospital:

Name:

PFI:

Race

- ○ White
- ○ Black
- ○ Asian / Pacific Islander
- ○ American Indian or Alaska Native
- ○ Multiracial
- ○ Not Specified
- ○ ND

Ethnicity

- ○ Non-Hispanic/Latino
- ○ Hispanic/Latino
- ○ Unknown
- ○ ND

Was patient transferred from another hospital? ○ Yes ○ No ○ Unknown

Name:

PFI:

Transfer Date:

Pregnant:

- ○ Yes
- ○ No
- ○ Unknown
- ○ Not applicable (males)

Patient resides in nursing home? ○ Yes ○ No ○ Unknown

If yes, nursing home name:

For optimum accuracy, please print in capital letters and avoid contact with the edge of the box.

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z