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LERNER-ELLIS - Implementation of serological and molecular tools for COVID-19 patient management 22-Mar-2021

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Participant Demographics And Information Gencov

Record ID

OHIP number

Email

Study Email

Demographics

Clinical centre/hospital name

Outpatient or Inpatient? (Based on when consented for study)

 Outpatient Inpatient

(If outpatient, complete outpatient data collection form only. If inpatient or ED complete inpatient and ED data collection form only.)

Country

Enrolment date/first COVID-19 assessment date (swab date)

Ethnic group

 Arab Black East Asian South Asian West Asian Latin American, White Aboriginal/First Nations Other Unknown

(Check all that apply)

If other, please specify

Employed as a healthcare worker?

 No Yes Unknown

Employed in a microbiology lab?

 No Yes Unknown

Age

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Sex Assigned at Birth	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Intersex <input type="radio"/> Not specified/Unknown
Pregnant	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Gestational weeks assessment	_____
Postpartum?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown (If no, skip this section)
Pregnancy outcome	<input type="radio"/> Live birth <input type="radio"/> Still birth <input type="radio"/> Unknown
Delivery date	_____
Baby tested for COVID-19?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
If yes, what was the test result?	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown
Infant < 1 year old?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown (If no, skip this section)
Birth weight (kg)	_____
Gestational outcome	<input type="radio"/> Term birth (greater than or equal to 37 weeks) <input type="radio"/> Pre-term birth (less than 37 weeks) <input type="radio"/> Unknown
Breastfed?	_____
Vaccinations appropriate for age/country?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

Study Progress Check Points (To be Filled by Sinai Team)

1 month blood requisition sent?	<input type="radio"/> No <input type="radio"/> Yes
Pre-test counselling scheduled?	<input type="radio"/> No <input type="radio"/> Yes ('Yes' will trigger intake questionnaire + baseline measures)
Pre-testing counselling completed?	<input type="radio"/> No <input type="radio"/> Yes ('Yes' will trigger T1 measures to be sent via email)

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Results delivered to participant?

No

Yes

('Yes' will trigger T2 outcome measures link to be sent via email / Followed by T3 outcome measures after 6 months)

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Comorbidities And Risk Factors Gencov

Record ID

Chronic cardiac disease (not hypertension) No Yes Unknown

Balloon angioplasty or percutaneous coronary intervention No Yes, Unknown

Coronary artery bypass No Yes Unknown

Myocardial infarction Type I No Yes Unknown

Myocardial infarction Type II No Yes Unknown

Hypertension No Yes Unknown

Coronary artery disease No Yes Unknown

Congestive heart failure No Yes Unknown

Chronic obstructive pulmonary disease (not asthma) No Yes Unknown

Asthma No Yes Unknown

Chronic lung disease No Yes Unknown

Cystic Fibrosis No Yes Unknown

Sleep Apnea No Yes Unknown

Home CPAP (continuous positive airway pressure) device used at night No Yes Unknown

Gallbladder disease No Yes Unknown

Obesity (as defined by clinical staff) No Yes Unknown

Diabetes Mellitus Type 1 Type 2 MODY
 Gestational No Unknown
 Unknown Type

Chronic metabolic disease No Yes Unknown

Chronic neurological disease No Yes Unknown

Dementia No Yes Unknown

Cerebrovascular disease No Yes Unknown

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Peripheral vascular disease	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Stroke	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Arrhythmias	<input type="radio"/> No <input type="radio"/> Yes, <input type="radio"/> Unknown
Down syndrome	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Chronic kidney disease	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Solid organ transplant	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Bone marrow transplant	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Chronic immunosuppressive disease	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Autoimmune/Rheumatologic disease	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Chronic hematologic/blood disease	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Sickle cell disease	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Thalassemia	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Gastrointestinal disease	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Liver disease	<input type="radio"/> Mild <input type="radio"/> Moderate or severe <input type="radio"/> No <input type="radio"/> Unknown
Asplenia	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Pancreatic disease	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Cancer/malignant neoplasm	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Patient age at diagnosis	_____
Leukemia	<input type="radio"/> No <input type="radio"/> Yes, <input type="radio"/> Unknown
Lymphoma	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Sarcoma	<input type="radio"/> No <input type="radio"/> Yes, <input type="radio"/> Unknown
Carcinoma	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Myeloma	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Mixed Types	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Other Cancer Type	_____

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Cancer Location

- Skin
 Lungs
 Breast
 Head and neck
 Digestive/Gastrointestinal
 Gynecologic
 Genitourinary (bladder, kidney, prostate, penile, testicular)
 Eye
 Musculoskeletal
 Germ cell/CNS
 Other
 Don't know

Specify other cancer location

Cancer treatment in the past 12 months (please mark all that apply)

- Surgery
 Chemotherapy
 Radiation therapy
 HSCT
 Immunotherapy
 Hormone therapy
 Clinical trials
 Other
 Don't know

Specify other cancer treatment

AIDS/HIV

- Yes-on ART Yes-not on ART
 No Unknown

Tuberculosis

- No Yes Unknown

Malnutrition

- No Yes Unknown

Smoking

- Yes Never smoked
 Former smoker Unknown

Pregnant

- No Yes Unknown

Other relevant risk factor(s)

- No Yes Unknown

If yes, please specify

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Inpatient and ED Admission Outcome Pre-med Gencov

Record ID

Inpatient or ED patient?

 Inpatient Emergency department (ED)

CTAS score

Onset and Admission

Admitted to (Hospital Name)

Date of hospital admission

ED Visit Date

Reason for visit

- Showing signs of COVID-19 symptoms
- Pre-travel (i.e. flights, visa)
- Exposure/close contact (e.g. COVID alert app, Local Public Health, sent by Occupational Health)
- Targeted testing (i.e. visitors/workers/residents of LTC/homeless shelter, Indigenous communities, farm worker, etc.)
- Live or work in setting with COVID-19 Outbreak
- Pre-treatment or pre-surgery
- Other (specify)

If other, specify

Multiple Visits to ED

 Yes No

ED Visit Date

Reason for visit

- Showing signs of COVID-19 symptoms
- Pre-travel (i.e. flights, visa)
- Exposure/close contact (e.g. COVID alert app, Local Public Health, sent by Occupational Health)
- Targeted testing (i.e. visitors/workers/residents of LTC/homeless shelter, Indigenous communities, farm worker, etc.)
- Live or work in setting with COVID-19 Outbreak
- Pre-treatment or pre-surgery
- Other (specify)

If other, specify

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ED Visit Date

Reason for visit

- Showing signs of COVID-19 symptoms
 Pre-travel (i.e. flights, visa)
 Exposure/close contact (e.g. COVID alert app, Local Public Health, sent by Occupational Health)
 Targeted testing (i.e. visitors/workers/residents of LTC/homeless shelter, Indigenous communities, farm worker, etc.)
 Live or work in setting with COVID-19 Outbreak
 Pre-treatment or pre-surgery
 Other (specify)

If other, specify

ICU or high dependency unit admission?

- No Yes Unknown

If yes, admission date
_____If yes, date of discharge
_____If yes, total duration (days)

Current admission to ICU/ITU/IMC/HDU?

- No Yes Unknown
 (Record the worst value on day of assessment for following questions)

Richmond Agitation-Sedation Scale (RASS)
_____Riker Sedation-Agitation Scale (SAS)
_____Onset date of first/earliest symptom

Was the patient Asymptomatic?

- Yes
 No

Was the patient admitted previously or transferred from any other facility during this illness episode?

- Yes- admitted previously to this facility
 Yes-transferred from other facility
 No Unknown

Name of transfer facility
_____ER triage date at transfer facility

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Has this patient's data previously been collected under a different patient number? No Yes Unknown

If yes, participant identification number (PIN)

Source study ID# from transfer facility

HostSeq study ID # from transfer facility

Signs and Symptoms (no multiple measure)

Height (inches)

Ambulatory state

No limitation of activities
 Limitation of activities

Pre-admission/Already On Medication

ACE inhibitors No Yes Unknown

If yes, list names

ARBs No Yes Unknown

If yes, list names

Oral steroids No Yes Unknown

If yes, list names

NSAIDs No Yes Unknown

If yes, list names

Other immunosuppressant agents (not oral steroids) Rituximab MMF
 Other No Unknown

If other, list names

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Antivirals Remdesivir Hydroxychloroquine (HCQ) Kaletra Ivermectin Other No Unknown

If other, list names

Antibiotics No Yes Unknown

If yes, list names

Other targeted COVID-19 medications No Yes Unknown

If yes, list names

Statins Yes No Unknown

If yes, list names

Novel Oral Anticoagulants (NOACs) Yes No Unknown

If yes, list names

Warfarin Yes No Unknown

Other Non-COVID related medications

(List any other medications)

Has the patient received BCG vaccine? No Yes Don't know

Patient Outcome

Outcome Discharged alive Hospitalized Transfer to other facility Death Palliative discharge Unknown

Outcome date

Transfer facility name

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If discharged alive, ability to self-care at discharge versus before illness:

- Same as before illness
 Worse Better Unknown

If discharged alive, post-discharge treatment (oxygen therapy):

- No Yes Unknown

Outcome

- Discharged alive Hospitalized
 Transfer to other facility
 Death Palliative discharge
 Unknown

Outcome date

Transfer facility name

If discharged alive, ability to self-care at discharge versus before illness:

- Same as before illness
 Worse Better Unknown

If discharged alive, post-discharge treatment (oxygen therapy):

- No Yes Unknown

Outcome

- Discharged alive Hospitalized
 Transfer to other facility
 Death Palliative discharge
 Unknown

Outcome date

Transfer facility name

If discharged alive, ability to self-care at discharge versus before illness:

- Same as before illness
 Worse Better Unknown

If discharged alive, post-discharge treatment (oxygen therapy):

- No Yes Unknown

Repeat hospital visit within 30 days?

- No Yes Don't know

Date of repeat hospital visit

Reason for repeat hospital visit

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Inpatient and ED Symptom Complication Treatment Diagnostics Repeat Form Gencov

Record ID _____

Date of Assessment _____

(For ED patient or multiple ED visits)

7 Day Date Range for Inpatient (M-D-Y to M-D-Y) _____

Select based on patient status

 Inpatient Data ED Visit Data

Signs and Symptoms

Fever (degrees C) _____

Fever

 No Yes Unknown
(38.0 degrees and above= qualifies as fever as per ISARIC)

Days with Fever

 Known
 Unknown

Number of days fever lasted _____

Cough

 No Yes-non-productive
 Yes-productive Yes-with haemoptysis
 Unknown

Days with cough _____

Sore Throat

 No Yes Unknown

Runny nose

 No Yes Unknown

Wheezing

 No Yes Unknown

Shortness of breath/Difficulty Breathing

 No Yes Unknown

Increase Respiratory Effort (e.g. accessory muscle use, chest wall indrawing, tripodding)

 No Yes Unknown

Chest pain

 No Yes Unknown

Conjunctivitis

 No Yes Unknown

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Lymphadenopathy	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown
Headache	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown
Loss of smell	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown
Loss of taste	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown
Nosebleed	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't know
Ear pain	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't know
Seizures	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown
Fatigue/malaise	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown
Anorexia	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown
Altered consciousness/confusion	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown
Myalgia/muscle aches	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown
Arthralgia/joint pain	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown
Inability to walk	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown
Abdominal pain	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown
Diarrhea	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown
Nausea/vomiting	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown
Skin rash	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown
Bleeding/haemorrhage	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown
If yes, please specify site(s)	_____		
Other symptom(s)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown
If yes, please specify	_____		
Any Allergies	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
If yes, please specify	_____		

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On Oxygen Type Room Air Oxygen Therapy
 Unknown

Any supplemental oxygen: FiO₂ (0.21-1.0) No Yes Unknown

Sternal capillary refill time >2s No Yes Unknown

APVU Alert Verbal Pain
 Unresponsive

Treatments and Interventions

High-flow nasal cannula oxygen therapy No Yes Unknown

Non-invasive ventilation No Yes Unknown

If yes, select: HFNC BIPAP Other

If other, specify:

If yes, total duration (days)

Invasive ventilation No Yes Unknown

If yes, total duration (days)

Prone positioning No Yes Unknown

If yes, total duration (days)

Inhaled nitric oxide No Yes Unknown

Tracheostomy inserted No Yes Unknown

Extra corporeal life support (ECLS/ECMO) No Yes Unknown

If yes: VV AV Central
 Unknown

If yes, total duration (days)

Renal replacement therapy (RRT) or dialysis No Yes Unknown

Any vasopressor/inotropic support? No Yes Unknown
 (If no, select 'no' for the next 3 questions)

Inotropes/vasopressors start date

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 Inotropes/vasopressors end date

 If yes, total duration (days)

 Dopamine < 5ug/kg/min OR Dobutamine OR milrinone OR levosimendan
 No
 Yes
 Unknown

 Dopamine 5-15ug/kg/min OR Epinephrine/Norepinephrine < 0.1ug/kg/min OR vasopressin OR phenylephrine
 No
 Yes
 Unknown

 Dopamine >15ug/kg/min OR Epinephrine/Norepinephrine > 0.1ug/kg/min
 No
 Yes
 Unknown

 Neuromuscular blocking agents
 No
 Yes
 Unknown

 Other interventions or procedures?
 No
 Yes
 Unknown

 If yes, specify

 Any oxygen therapy?
 No
 Yes
 Unknown

 If yes, total duration (days)

 If yes, max O2 flow volume
 < 2 L/min
 2-5 L/min
 6-10 L/min
 11-15 L/min
 >15 L/min

 Convalescent blood transfusion
 No
 Yes
 Unknown

 If yes, adverse reaction?
 No
 Yes
 Unknown

 If yes, type of adverse reaction
 Acute lung injury
 Allergic reaction
 Circulatory overload
 Other

 If other adverse reaction, specify

Complications

 Viral pneumonia/pneumonitis
 No
 Yes
 Unknown

 Bacterial pneumonia
 No
 Yes
 Unknown

 Confirmed
 Clinically
 By Imaging
 Other

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 If Other, please specify _____

 Acute Respiratory Distress Syndrome No Yes Unknown

 If yes, specify Mild Moderate Severe
 Unknown

 Pneumothorax No Yes Unknown

 Pleural effusion No Yes Unknown

 Cryptogenic organizing pneumonia No Yes Unknown

 Bronchiolitis No Yes Unknown

 Cardiac arrest No Yes Unknown

 Myocardial infarction No Yes Unknown

 Cardiac ischaemia No Yes Unknown

 Specify type of cardiac ischaemia STEMI NSTEMI
 Cath Stent

 Cardiac arrhythmia No Yes Unknown

 Specify type(s) of cardiac arrhythmia AF VT/VF Other

 Specify other type(s) of cardiac arrhythmia _____

 Myocarditis/Pericarditis No Yes Unknown

 Endocarditis No Yes Unknown

 Cardiomyopathy No Yes Unknown

 Type of Cardiomyopathy Dilated Cardiomyopathy (DCM)
 Hypertrophic Cardiomyopathy (HCM)
 Restrictive Cardiomyopathy (RCM)
 Left Ventricular Non-Compaction (LVNC)
 Arrhythmogenic Right Ventricular Dysplasia (ARVD)

 Congestive heart failure No Yes Unknown

 Specify left ventricular ejection fraction status Normal Decreased

 Specify % decrease _____

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Seizures	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Stroke/Cerebrovascular accident	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Meningitis/Encephalitis	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Bacteremia	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Coagulation disorder/DIC	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Pulmonary embolism	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Anemia	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Rhabdomyolysis	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Acute renal injury/failure	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Gastrointestinal haemorrhage	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Pancreatitis	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Liver dysfunction	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Hyperglycemia	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Hypoglycemia	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Inflammatory syndrome/Kawasaki disease like	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
Other complications	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
If yes, specify	_____

Diagnostics

Was pathogen testing done during this illness episode?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown (If 'yes' complete the rest of this section)
Coronavirus	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done
If positive for coronavirus:	<input type="radio"/> COVID-2019/SARS-CoV2 <input type="radio"/> MERS CoV <input type="radio"/> Other CoV <input type="radio"/> Unknown
If other CoV, specify	_____
Collection date	_____

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Biospecimen type

- Nasal/NP swab Throat swab
 Combined nasal/NP+throat swab
 Sputum BAL ETA
 Urine Feces/rectal swab
 Blood Other

If other, specify

Laboratory test method

- PCR Culture Other

If other, specify

Time to Viral Clearance (Days)

(Days between positive and negative swab)

Influenza

- Positive Negative
 Not done

If positive for influenza:

- A/H3N2 A/H1N1pdm09
 A/H7N9 A/H5N1
 A-not typed B Other
 Unknown

If other, specify

Collection date

Biospecimen type

- Nasal/NP swab Throat swab
 Combined nasal/NP+throat swab
 Sputum BAL ETA
 Urine Feces/rectal swab
 Blood Other

If other, specify

Laboratory test method

- PCR Culture Other

If other, specify

RSV

- Positive Negative
 Not done

Collection date

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Biospecimen type

- Nasal/NP swab Throat swab
 Combined nasal/NP+throat swab
 Sputum BAL ETA
 Urine Feces/rectal swab
 Blood Other

If other, specify

Laboratory test method

- PCR Culture Other

If other, specify

Adenovirus

- Positive Negative
 Not done

Collection date

Biospecimen type

- Nasal/NP swab Throat swab
 Combined nasal/NP+throat swab
 Sputum BAL ETA
 Urine Feces/rectal swab
 Blood Other

If other, specify

Laboratory test method

- PCR Culture Other

If other, specify

Bacteria

- Positive Negative
 Not done

Specify Bacteria Type

- Streptococcus pneumoniae
 Staphylococcus aureus
 Group A streptococcus
 Escherichia coli
 Klebsiella pneumoniae
 Other

Specify other bacteria type

Specify location(s)

- Blood
 Lower respiratory tract
 Urine
 Bone or joint
 CNS
 Other

Specify other location(s)

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Collection date

Biospecimen type

- Nasal/NP swab Throat swab
 Combined nasal/NP+throat swab
 Sputum BAL ETA
 Urine Feces/rectal swab
 Blood Other

If other, specify

Laboratory test method

- PCR Culture Other

If other, specify

Other pathogen(s) detected

- No Yes Unknown

If yes, specify

Other Pathogen Result

- Positive Negative
 Unknown

Collection date

Biospecimen type

- Nasal/NP swab Throat swab
 Combined nasal/NP+throat swab
 Sputum BAL ETA
 Urine Feces/rectal swab
 Blood Other

If other, specify

Laboratory test method

- PCR Culture Other

If other, specify

Enterovirus

- Negative Yes - Confirmed
 Yes - Probable Not tested

Collection date

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Biospecimen type	<input type="radio"/> Nasal/NP swab <input type="radio"/> Throat swab <input type="radio"/> Combined nasal/NP+throat swab <input type="radio"/> Sputum <input type="radio"/> BAL <input type="radio"/> ETA <input type="radio"/> Urine <input type="radio"/> Feces/rectal swab <input type="radio"/> Blood <input type="radio"/> Other
If other, specify	_____
Laboratory test method	<input type="radio"/> PCR <input type="radio"/> Culture <input type="radio"/> Other
If other, specify	_____
Clinical pneumonia diagnosed?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
NONE OF THE ABOVE: Suspected Non-infective	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
Chest X-ray performed?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Ground Glass Opacities (GGOs) present?	<input type="radio"/> Multifocal <input type="radio"/> Bilateral <input type="radio"/> Peripheral
GGOs Lobe Location	_____
	(Write lobe location for GGOs)
If yes, infiltrates present?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
CT performed?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
If yes, infiltrates present?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
ECG	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
POCUS	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
Echocardiogram	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know

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Inpatient Ed Medications In Hospital Gencov

Record ID

Select based on patient status

 Inpatient Data ED Visit Data

Medication (ANY) while hospitalized or at discharge

Antiviral or COVID-19 targeted agent?

 No Yes Unknown
(If yes, specify agents and duration below)

Ribavirin

 No Yes Unknown

Date commenced

Duration (days)

Lopinavir/Ritonavir

 Yes No Unknown

Date commenced

Duration (days)

Remdesivir

 No Yes Unknown

Date commenced

Duration (days)

Plasma

 No Yes Don't know

Date commenced

Duration (days)

Interferon alpha

 No Yes Unknown

Date commenced

Duration (days)

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Interferon beta No Yes Unknown

Date commenced _____

Duration (days) _____

Chloroquine/hydroxychloroquine No Yes Unknown

Date commenced _____

Duration (days) _____

Neuraminidase inhibitor No Yes Don't know

Date commenced _____

Duration (days) _____

If yes, specify names, date of commencement, and duration

(Non-COVID)

Antibiotic? No Yes Unknown

Other drug/medication No Yes Unknown
(Non-COVID)

Is yes, specify agent(s), date of commencement, and duration (days)

If yes, route: Oral IV Inhaled
 Unknown

If oral or IV, please provide agent and max. daily dose & unit

Corticosteroids? No Yes Unknown

Date commenced _____

Duration (days) _____

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Heparin No Yes Unknown

If yes, route: Subcutaneous IV
 Unknown

If yes: Unfractionated Low molecular weight
 Fondaparinux Unknown

Heparin Dose Unit _____

Date commenced _____

Heparin Dose Type Full Dose Intermediate Dose

Duration (days) _____

Antifungal agent No Yes Unknown

Date commenced _____

Duration (days) _____

Colchicine No Yes Don't know

Date commenced _____

Duration (days) _____

Tocilizumab (Actemra) No Yes Don't know

Date commenced _____

Duration (days) _____

Kineret (Anakinra) No Yes Don't know

Date commenced _____

Duration (days) _____

Intravenous Immune Globulin (IVIG) No Yes Don't know

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Date commenced

Duration (days)

Other treatments administered for COVID-19 including experimental and compassionate use?

No Yes Unknown

If yes, specify agent, date commenced, and duration (days)

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Outpatient Data Collection Form Gencov

Record ID

Onset and Admission

Onset date of first/earliest symptom

Most recent presentation/symptom

Was the patient Asymptomatic?

- No
 Yes

Reason for visit

- Showing signs of COVID-19 symptoms
 Pre-travel (i.e. flights, visa)
 Exposure/close contact (e.g. COVID alert app, Local Public Health, sent by Occupational Health)
 Targeted testing (i.e. visitors/workers/residents of LTC/homeless shelter, Indigenous communities, farm worker, etc.)
 Live or work in setting with COVID-19 Outbreak
 Pre-treatment or pre-surgery
 Other (specify)

If other, specify reason for visit

Signs and Symptoms

Allergies

- No Yes Unknown

If yes, specify

Heart rate

Systolic blood pressure (mmHg)

Diastolic blood pressure (mmHg)

Respiratory rate

Oxygen saturation (SaO₂)

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Height (inches)

Weight (lbs)

Fever

No Yes Unknown
 (38.0 degrees and above= qualifies as fever as per ISARIC)

Temperature

Time to viral clearance (days)

Cough

No Yes-non-productive
 Yes-productive Yes-with haemoptysis
 Unknown

Days with cough

Sore Throat

No Yes Unknown

Runny nose

No Yes Unknown

Wheezing

No Yes Unknown

Shortness of breath/Difficulty Breathing

No Yes Unknown

Lower chest wall indrawing

No Yes Unknown

Chest pain

No Yes Unknown

Conjunctivitis

No Yes Unknown

Lmyphadenopathy

No Yes Unknown

Headache

No Yes Unknown

Loss of smell

No Yes Unknown

Nosebleed

No Yes Don't know

Loss of taste

No Yes Unknown

Ear pain

No Yes Don't know

Seizures

No Yes Unknown

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Fatigue/malaise No Yes Unknown

Anorexia No Yes Unknown

Altered consciousness/confusion No Yes Unknown

Myalgia/muscle aches No Yes Unknown

Arthralgia/joint pain No Yes Unknown

Inability to walk No Yes Unknown

Abdominal pain No Yes Unknown

Diarrhea No Yes Unknown

Nausea/vomiting No Yes Unknown

Skin rash No Yes Unknown

Bleeding/haemorrhage No Yes Unknown

If yes, please specify site(s)

Other symptom(s) No Yes Unknown

If yes, please specify

Medications

ACE inhibitors No Yes - Pre-admission/clinic visit
 Yes - Prescribed in clinic/hospital
 Unknown

If yes, which medication:
 Benazepril (Lotensin)
 Captopril (Capoten)
 Enalapril (Vasotec)
 Other

If other, specify

Notes

Has the patient received BCG vaccine? No
 Yes
 Don't know

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ARBs No Yes - Pre-admission/clinic visit
 Yes - Prescribed in clinic/hospital
 Unknown

If yes, which medication: Candesartan (Atacand)
 Eprosartan (Tevetan)
 Irbesartan (Avapro)
 Other

If other, specify _____

Notes _____

NSAIDs No Yes - Pre-admission/clinic visit
 Yes - Prescribed in clinic/hospital
 Unknown

If yes, which medication: Aspirin (Bayer)
 Ibuprofen (Advil, Motrin)
 Naproxen (Aleve)
 Other

If other, specify _____

Notes _____

Oral steroids No Yes - Pre-admission/clinic visit
 Yes - Prescribed in clinic/hospital
 Unknown

If yes, which medication: Prednisolone
 Betamethasone
 Dexamethasone
 Hydrocortisone
 Other

If other, specify _____

Notes _____

Other immunosuppressant agents (not oral steroids) No Yes - Pre-admission/clinic visit
 Yes - Prescribed in clinic/hospital
 Unknown

If yes, which medication: Mycophenolate mofetil (MMF)
 Rituximab
 Other

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If other, specify

Notes

Antivirals

- No Yes - Pre-admission/clinic visit
 Yes - Prescribed in clinic/hospital
 Unknown

If yes, which medication:

- Remdesivir
 Hydroxychloroquine (HCQ)
 Kalertra
 Ivermectin
 Other

If other, specify

Notes

Antibiotics

- No Yes - Pre-admission/clinic visit
 Yes - Prescribed in clinic/hospital
 Unknown

If yes, which medication:

- Amoxicillin
 Doxycycline
 Cephalexin
 Ciprofloxacin
 Other

If other, specify

Notes

Other Novel Anticoagulants (NOACs)

- No Yes - Pre-admission/clinic visit
 Yes - Prescribed in clinic/hospital
 Unknown

If yes, which medication:

- Rivaroxaban (e.g. Xarelto)
 Dabigatran (e.g. Pradaxa)
 Apixaban (e.g. Eliquis)
 Edoxaban (e.g. Lixiana)
 Other

If other, specify

Notes

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Warfarin No Yes - Pre-admission/clinic visit
 Yes - Prescribed in clinic/hospital
 Unknown

Lipid-lowering therapies No Yes - Pre-admission/clinic visit
 Yes - Prescribed in clinic/hospital
 Unknown

If yes, which medication: Statin (e.g. Lipitor, Lescol, Lipostat)
 Ezetimibe
 Bile acid sequestrants
 Other

If other, specify _____

Notes _____

Other targeted COVID-19 medications (e.g. colchicine) No Yes - Pre-admission/clinic visit
 Yes - Prescribed in clinic/hospital
 Unknown

If yes, specify _____

Notes _____

Other Medications No Yes - Pre-admission/clinic visit
 Yes - Prescribed in clinic/hospital
 Unknown

If yes, specify _____

Notes _____

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Page 1

Signs And Biochemical Data Repeat Form Gencov

Record ID

Date of Assessment

(For ED patient or multiple ED visits)

Select based on patient status

 Inpatient Data ED Visit Data

Vital Signs Clinical Data

Temperature (degrees C)

Temperature Reference Interval

(Type in the reference interval)

The temp is

- Normal
 High
 Critically High
 Low
 Critically Low
(Select based on reference interval and result value)

Heart rate (beats/min)

Heart rate Reference Interval

(Type in the reference interval)

The Heart Rate is

- Normal
 High
 Critically High
 Low
 Critically Low
(Select based on reference interval and result value)

Respiratory rate (breaths/min)

Respiratory Rate Reference Interval

(Type in the reference interval)

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The Respiratory Rate is

Normal
 High
 Critically High
 Low
 Critically Low
(Select based on reference interval and result value)

Systolic blood pressure (mmHg)

Systolic BP Reference Interval

(Type in the reference interval)

The Systolic blood pressure is

Normal
 High
 Critically High
 Low
 Critically Low
(Select based on reference interval and result value)

Diastolic blood pressure (mmHg)

Diastolic BP Reference Interval

(Type in the reference interval)

The Diastolic blood pressure is

Normal
 High
 Critically High
 Low
 Critically Low
(Select based on reference interval and result value)

Mean arterial blood pressure (mmHg)

Mean Arterial BP Reference Interval

(Type in the reference interval)

The Mean arterial blood pressure is

Normal
 High
 Critically High
 Low
 Critically Low
(Select based on reference interval and result value)

Weight (lbs)

Glasgow Coma Score (GCS / 15)

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GCS Reference Interval

(Type in the reference interval)

The Glasgow Coma Score is

- Normal
 High
 Critically High
 Low
 Critically Low
(Select based on reference interval and result value)

Urine flow rate (mL/24 hours)

The Urine flow rate is

- Normal
 High
 Critically High
 Low
 Critically Low
(Select based on reference interval and result value)

Biochemical Study Data

Haemoglobin (g/L)

- Yes
 Not Done

Haemoglobin (g/L)

Haemoglobin Reference Interval

(Type in the reference interval)

The Hemoglobin is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

WBC Count

- Yes
 Not Done

WBC count ($\times 10^9/L$)

WBC Count Reference Interval

(Type in the reference interval)

The WBC count is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Lymphocyte count

- Yes
 Not Done

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Lymphocyte count (x10⁹/L)

Lymphocyte count Reference Interval

The Lymphocyte count is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Neutrophil count

- Yes
 Not Done

Neutrophil count (x10⁹/L)

Neutrophil count Reference Interval

The Neutrophil count is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Hematocrit count

- Yes
 Not Done

Haematocrit (%)

Haematocrit Reference Interval

The Hematocrit is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Platelets Count

- Yes
 Not Done

Platelets (x10⁹/L)

Platelets Reference Interval

The Platelets count is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Oxygen saturation test

- Yes
 Not Done

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 Blood Gas: Oxygen saturation (%)

 O2 saturation Reference Interval

 The Oxygen Saturation is

- Normal High Critically High
 Low Critically Low
 (Select based on reference interval and result value)
-

 PaO2 test

- Yes
 Not Done
-

 PaO2 (at time nearest to the FiO2 recorded in inpatient form) (indicate kPa or mmHg)

 PaO2 sample type

- Arterial Capillary
 Unknown
-

 PaO2 Reference Interval

 The PaO2 is

- Normal High Critically High
 Low Critically Low
 (Select based on reference interval and result value)
-

 PCO2 test

- Yes
 Not Done
-

 PCO2 (indicate kPa or mmHg)

(From same blood gas record as PaO2)

 PCO2 Reference Interval

 The PCO2 is

- Normal High Critically High
 Low Critically Low
 (Select based on reference interval and result value)
-

 pH test

- Yes
 Not Done
-

 pH

(From same blood gas record as PaO2)

 pH Reference Interval

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The pH is Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

HCO₃⁻ TEST Yes
 Not Done

HCO₃⁻ (mEq/L) _____
(From same blood gas record as PaO₂)

HCO₃⁻ Reference Interval _____

The HCO₃⁻ is Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Base excess (mmol/L) _____
(From same blood gas record as PaO₂)

Base Excess Reference Interval _____

The Base Excess is Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

APTT Test Yes
 Not Done

Activated Partial Thromboplastin time/APTT (seconds) _____

APTT Reference Interval _____

The APTT is Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Activated Partial Thromboplastin time ratio/APTR _____

APTR Reference Interval _____

The APTR is Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

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Prothrombin Test

- Yes
 Not Done

Prothrombin time/PT (seconds)

PT Reference Interval

The Prothrombin time/PT is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

INR Test

- Yes
 Not Done

INR

INR Reference Interval

The INR is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

ALT/SGPT Test

- Yes
 Not Done

ALT/SGPT (U/L)

ALT Reference Interval

The ALT is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Bilirubin Test

- Yes
 Not Done

Total bilirubin (umol/L)

Bilirubin Reference Interval

The Bilirubin is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

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AST/SGOT Test

- Yes
 Not Done

AST/SGOT (U/L)

AST Reference Interval

The AST (U/L) is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Procalcitonin Test

- Yes
 Not Done

Procalcitonin (ng/L)

Procalcitonin Reference Interval

The Procalcitonin is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

BNP Test

- Yes
 Not Done

BNP (ng/L)

BNP Reference Interval

The BNP is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

NT-proBNP Test

- Yes
 Not Done

NT-proBNP (ng/L)

NT-proBNP Reference Interval

The NT-proBNP is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

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C-reactive protein Test

- Yes
 Not Done

C-reactive protein (mg/L)

C-reactive Reference Interval

The C-reactive protein is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Ferritin Test

- Yes
 Not Done

Ferritin (ug/L)

Ferritin Reference Interval

The Ferritin is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Cytokine Test

- Yes
 Not Done

Cytokine IL-6 (pg/mL)

Cytokine Reference Interval

The Cytokine is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Glucose Test

- Yes
 Not Done

Glucose (mmol/L)

Glucose Reference Interval

The Glucose is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

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Lactate Test

- Yes
 Not Done

Lactate (mmol/L)

Lactate Reference Interval

The Lactate is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Sodium Test

- Yes
 Not Done

Sodium (mmol/L)

Sodium Reference Interval

The Sodium is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Potassium Test

- Yes
 Not Done

Potassium (mmol/L)

Potassium Reference Interval

The Potassium is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Albumin Test

- Yes
 Not Done

Albumin

Albumin Reference Interval

The Albumin is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

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LDH Test Yes
 Not Done

LDH (U/L)

LDH Reference Interval

The LDH is Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Creatinine Test Yes
 Not Done

Creatinine (umol/L)

Creatinine Reference Interval

The Creatinine is Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Creatine Kinase Test Yes
 Not Done

Creatine kinase (U/L)

Creatine kinase Reference Interval

The Creatine Kinase is Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Urea Test Yes
 Not Done

Urea (BUN) (mmol/L)

Urea Reference Interval

The Urea is Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

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Troponin Test Yes
 Not Done

Cardiac troponin I (ng/L)

Cardiac Troponin Reference Interval

The Cardiac troponin is Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

D-dimer Test Yes
 Not Done

D-dimer (ng/mL)

D-dimer Reference Interval

The D-dimer is Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Fibrinogen Test Yes
 Not Done

Fibrinogen (g/L)

Fibrinogen Reference Interval

The Fibrinogen is Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

Triglycerides Test Yes
 Not Done

Triglycerides (mg/dL)

Triglycerides Reference Interval

The Triglycerides is Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)

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CD4/CD8 Test

- Yes
 Not Done

CD4 result (cells/mm)

CD8 result (cells/mm)

CD4/CD8 ratio result

CD4//CD8 Reference Interval

The CD4/CD8 ratio is

- Normal High Critically High
 Low Critically Low
(Select based on reference interval and result value)