……PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC……

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): ____/_____/_____

……PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC……

COVID-19 Case Chart Abstraction Form

Record ID: CO_____

EIP ID (if available): _____

Abstractor information

Name of abstractor: Last _____ First_____

Affiliation/Organization: _____

Telephone _____ Email _____

Date of medical chart abstraction: _____ (MM/DD/YYYY)

Data sources used for this form?

☐ CORHIO ☐ CEDRS ☐ EIP Chart Abstraction ☐ Other source, specify:_____

Was this case-patient hospitalized? ☐ Yes ☐ No

Hospitalization

1. Hospital name: _____ Hospital phone: _____
2. Admission date 1 ___/___/___ (MM/DD/YYYY) , discharge date 1 ___/___/____ (MM/DD/YYYY) ☐ Patient still hospitalized
3. Was their COVID-19 illness the initial reason for hospitalization? ☐ Yes ☐ No ☐ Unknown
   If no, what was the non-COVID-19 reason for hospitalization: _____
4. To where was the patient discharged?
   ☐ Home ☐ Home with services ☐ Transferred to another hospital ☐ LTCF ☐ Acute Rehab ☐ Hospice ☐ Deceased
   ☐ Homeless ☐ Incarcerated ☐ Other _____ ☐ Unknown

5. If hospitalized more than once, please enter the second hospitalization's admission and discharge dates: [if there are more than two hospitalizations please use the notes section]
   Hospital name 2: _____ Hospital phone 2: _____
   Admission date 2 _____/_____/_____ (MM/DD/YYYY) Discharge date 2_____/_____/_____ (MM/DD/YYYY)
   ☐ Patient still hospitalized
6. To where was the patient discharged from hospital 2?
   ☐ Home ☐ Home with services ☐ Transferred to another hospital ☐ LTCF ☐ Acute Rehab ☐ Hospice ☐ Deceased
   ☐ Homeless ☐ Incarcerated ☐ Other _____ ☐ Unknown

7. Symptom onset date: _____/_____/_____ (MM/DD/YYYY)

8. Did the patient report any of the following symptoms occurring prior to presentation?

Symptom	Symptom Present?	Date of Onset (MM/DD/YY)
Fever >100.4F (38C)	☐ Yes ☐ No ☐ Unknown	
Highest temp_____ °F		
Subjective fever (felt feverish)	☐ Yes ☐ No ☐ Unknown	
Chills	☐ Yes ☐ No ☐ Unknown	
Sweats	☐ Yes ☐ No ☐ Unknown	
Dehydration	☐ Yes ☐ No ☐ Unknown	

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Symptom	Symptom Present?	Date of Onset (MM/DD/YY)
Cough (new onset or worsening of chronic cough)	☐ Yes ☐ No ☐ Unknown	
Dry	☐ Yes ☐ No ☐ Unknown	
Productive	☐ Yes ☐ No ☐ Unknown	
Bloody sputum (hemoptysis)	☐ Yes ☐ No ☐ Unknown	
Sore throat	☐ Yes ☐ No ☐ Unknown	
Wheezing	☐ Yes ☐ No ☐ Unknown	
Shortness of breath (dyspnea)	☐ Yes ☐ No ☐ Unknown	
Runny nose (rhinorrhea)	☐ Yes ☐ No ☐ Unknown	
Stuffy nose (nasal congestion)	☐ Yes ☐ No ☐ Unknown	
Loss of smell (Anosmia)	☐ Yes ☐ No ☐ Unknown	
Loss of taste (Ageusia)	☐ Yes ☐ No ☐ Unknown	
Swollen Lymph Nodes (Lymphadenopathy)	☐ Yes ☐ No ☐ Unknown	
Eye redness (conjunctivitis)	☐ Yes ☐ No ☐ Unknown	
Rash	☐ Yes ☐ No ☐ Unknown	
Abdominal pain	☐ Yes ☐ No ☐ Unknown	
Vomiting	☐ Yes ☐ No ☐ Unknown	
Nausea	☐ Yes ☐ No ☐ Unknown	
Loss of appetite (anorexia)	☐ Yes ☐ No ☐ Unknown	
Diarrhea (>3 loose stools/day)	☐ Yes ☐ No ☐ Unknown	
Chest Pain	☐ Yes ☐ No ☐ Unknown	
Muscle aches (myalgia)	☐ Yes ☐ No ☐ Unknown	
Joint Pain (Arthralgia)	☐ Yes ☐ No ☐ Unknown	
Headache	☐ Yes ☐ No ☐ Unknown	
Fatigue	☐ Yes ☐ No ☐ Unknown	
Seizures	☐ Yes ☐ No ☐ Unknown	
Altered Mental Status (confusion)	☐ Yes ☐ No ☐ Unknown	
Other, specify:	☐ Yes ☐ No ☐ Unknown	
Other, specify:	☐ Yes ☐ No ☐ Unknown	
Other, specify:	☐ Yes ☐ No ☐ Unknown	
Other, specify:	☐ Yes ☐ No ☐ Unknown	

9. **List any medication that the individual taking prior to admission.**

☐ No medication listed; ☐ Reported not taking any medications prior to admission

Medication Name	Route	Frequency	Taking prior to illness onset?
	☐ PO ☐ Injection ☐ Topical ☐ Inhaled ☐ Other _____	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown ☐ Other _____	☐ Yes ☐ No ☐ Unknown
	Indication: _____		
	☐ PO ☐ Injection ☐ Topical ☐ Inhaled ☐ Other _____	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown ☐ Other _____	☐ Yes ☐ No ☐ Unknown

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	Indication: ______________________		
	☐ PO ☐ Injection ☐ Topical ☐ Inhaled ☐ Other __________	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown ☐ Other __________	☐ Yes ☐ No ☐ Unknown
	Indication: ______________________		
	☐ PO ☐ Injection ☐ Topical ☐ Inhaled ☐ Other __________	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown ☐ Other __________	☐ Yes ☐ No ☐ Unknown
	Indication: ______________________		
	☐ PO ☐ Injection ☐ Topical ☐ Inhaled ☐ Other __________	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown ☐ Other __________	☐ Yes ☐ No ☐ Unknown
	Indication: ______________________		
	☐ PO ☐ Injection ☐ Topical ☐ Inhaled ☐ Other __________	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown ☐ Other __________	☐ Yes ☐ No ☐ Unknown
	Indication: ______________________		

***If more than 6 medications listed by patient please fill out additional medication section at the end of the questionnaire.*

10. First recorded vital signs (*AT PRESENTATION, e.g. IN THE ED FOR HOSPITALIZED CASES*): Temp_________ (Unit: ☐ °F / ☐ °C)

Heart rate: _________ Resp rate:___________ Blood pressure: ________ mmHg (systolic) /_________ mmHg (diastolic)

O2 Sat: _______________

Type of support required when O2 saturation was measured:

☐ Room Air ☐ Nasal Cannula ☐ Face Mask ☐ CPAP or BIPAP ☐ High Flow Nasal Cannula ☐ Invasive mechanical ventilation
☐ Other, specify: ______________________________ ☐ Unknown

Fraction of Inspired Oxygen/Flow ___________ ☐ % ☐ Liters/minute (LPM) ☐ Unknown ☐ NA

Height (in cm): _________ Weight (in kg): __________ BMI (if recorded in medical records): _____________

11. Lung exam normal: ☐ Yes ☐ No ☐ Unknown
If abnormal lung exam, describe: ____

12. Admitting Diagnoses

Admitting Diagnosis	**ICD-10-CM Code**
1.	
2.	
3.	

13. Did the patient have any of the following pre-existing medical conditions? *(select all that apply)*

Chronic Lung Diseases	☐ Yes	☐ No	☐ Unknown
Asthma/reactive airway disease	☐ Yes	☐ No	☐ Unknown
Emphysema/Chronic Obstructive Pulmonary Disease (COPD)/Chronic Bronchitis	☐ Yes	☐ No	☐ Unknown
Interstitial lung disease	☐ Yes	☐ No	☐ Unknown
Pulmonary fibrosis	☐ Yes	☐ No	☐ Unknown

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Restrictive lung disease	☐ Yes	☐ No	☐ Unknown
Sarcoidosis	☐ Yes	☐ No	☐ Unknown
Cystic Fibrosis	☐ Yes	☐ No	☐ Unknown
Chronic hypoxemic respiratory failure with O2 requirement (Do you use oxygen at home?)	☐ Yes	☐ No	☐ Unknown
Obstructive sleep apnea (OSA)	☐ Yes	☐ No	☐ Unknown
Other chronic lung disease	☐ Yes	☐ No	☐ Unknown
If Yes, specify: _____			
Active tuberculosis	☐ Yes	☐ No	☐ Unknown
Cardiovascular (CV) diseases	☐ Yes	☐ No	☐ Unknown
Hypertension (high blood pressure)	☐ Yes	☐ No	☐ Unknown
Coronary artery disease (heart attack)	☐ Yes	☐ No	☐ Unknown
Heart failure/Congestive heart failure	☐ Yes	☐ No	☐ Unknown
Cerebrovascular accident/Stroke	☐ Yes	☐ No	☐ Unknown
Congenital heart disease (childhood heart problem)	☐ Yes	☐ No	☐ Unknown
Valvular Heart Disease (abnormal heart valve[s] – e.g., aortic stenosis, mitral regurgitation)	☐ Yes	☐ No	☐ Unknown
Arrhythmia (abnormal/irregular heartbeat or rhythm)	☐ Yes	☐ No	☐ Unknown
Other CV disease (e.g. peripheral artery disease, aortic aneurysm, cardiomyopathy, or other heart or vessel diseases specified by the patient)	☐ Yes	☐ No	☐ Unknown
If Yes, specify: _____			
Endocrine disorders	☐ Yes	☐ No	☐ Unknown
Diabetes Mellitus (DM)	☐ Yes	☐ No	☐ Unknown
If yes, specify DM Type 1 or 2	☐ Yes	☐ No	☐ Unknown
If yes, what last HgA1c? (Hemoglobin A1c or "A1c")? _____ Date (MM/YY)_____			☐ Unknown
Pre-diabetes	☐ Yes	☐ No	☐ Unknown
If yes, what last HgA1c? (Hemoglobin A1c or "A1c")? _____ Date (MM/YY)_____			☐ Unknown
Other endocrine (hormone) disorder (e.g. pituitary problems, hyperthyroidism, hypothyroidism, Addison's disease, Cushing's syndrome	☐ Yes	☐ No	☐ Unknown
If Yes, specify: _____			
Renal diseases	☐ Yes	☐ No	☐ Unknown
Chronic kidney disease/insufficiency	☐ Yes	☐ No	☐ Unknown
End-stage renal disease	☐ Yes	☐ No	☐ Unknown
Dialysis	☐ Yes	☐ No	☐ Unknown
If yes, specify type: hemodialysis (HD) or peritoneal	☐ HD	☐ Peritoneal	☐ Unknown
Other	☐ Yes	☐ No	☐ Unknown
If Yes, specify: _____			
Liver diseases	☐ Yes	☐ No	☐ Unknown
Alcoholic hepatitis	☐ Yes	☐ No	☐ Unknown
Chronic liver disease	☐ Yes	☐ No	☐ Unknown
Cirrhosis/End stage liver disease	☐ Yes	☐ No	☐ Unknown
Hepatitis B, chronic	☐ Yes	☐ No	☐ Unknown
Hepatitis C, chronic	☐ Yes	☐ No	☐ Unknown

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Non-alcoholic fatty liver disease (NAFLD)/NASH	☐ Yes	☐ No	☐ Unknown
Other	☐ Yes	☐ No	☐ Unknown
If Yes, specify: _____			
Autoimmune disorders	☐ Yes	☐ No	☐ Unknown
Rheumatoid arthritis	☐ Yes	☐ No	☐ Unknown
Systemic lupus	☐ Yes	☐ No	☐ Unknown
Other	☐ Yes	☐ No	☐ Unknown
If Yes, specify: _____			
Hematologic disorders	☐ Yes	☐ No	☐ Unknown
Anemia	☐ Yes	☐ No	☐ Unknown
If Yes, specify: _____			
Sickle cell disease	☐ Yes	☐ No	☐ Unknown
Sickle cell trait	☐ Yes	☐ No	☐ Unknown
Bleeding or clotting disorders	☐ Yes	☐ No	☐ Unknown
If Yes, specify: _____			
Other hematologic (blood) disorders	☐ Yes	☐ No	☐ Unknown
If Yes, specify: _____			
Immunocompromised Conditions	☐ Yes	☐ No	☐ Unknown
HIV infection	☐ Yes	☐ No	☐ Unknown
If yes, what was last CD4 Count? _____ Date (MM/YY)_____			☐ Unknown
AIDS or CD4 count <200	☐ Yes	☐ No	☐ Unknown
Solid organ transplant	☐ Yes	☐ No	☐ Unknown
Stem cell transplant (e.g., bone marrow transplant)	☐ Yes	☐ No	☐ Unknown
Leukemia	☐ Yes	☐ No	☐ Unknown
Lymphoma	☐ Yes	☐ No	☐ Unknown
Multiple myeloma	☐ Yes	☐ No	☐ Unknown
Splenectomy/asplenia	☐ Yes	☐ No	☐ Unknown
Other:	☐ Yes	☐ No	☐ Unknown
If Yes, specify: _____			
Cancer	☐ Yes	☐ No *(skip to next section)*	☐ Unknown *(skip to next section)*
If yes, what type of cancer? _____			
Year diagnosed? _____			
Cancer treatment include any of the following? *(If yes, specify what years you received treatment)*			
IV Chemotherapy	☐ Yes	☐ No	☐ Unknown Year(s): _____
Oral chemotherapy (pills)	☐ Yes	☐ No	☐ Unknown Year(s): _____

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Radiation	☐ Yes	☐ No	☐ Unknown	Year(s): _____
Other: _____	☐ Yes	☐ No	☐ Unknown	Year(s): _____

Neurologic/neurodevelopmental disorder: do you have any diseases of the brain, spinal cord, or nerves?	☐ Yes	☐ No	☐ Unknown
If Yes, specify: _____			
Psychiatric Diagnosis: do you have any mental health problems? (e.g. depression, bipolar disorder, anxiety disorder, schizophrenia)	☐ Yes	☐ No	☐ Unknown
If Yes, specify: _____			
Other chronic diseases:	☐ Yes	☐ No	☐ Unknown
If Yes, specify: _____			

14. Did the patient develop any of the following symptoms during their hospitalization for this illness?

Symptom	Symptom Present?	Date of Onset (MM/DD/YY)
Fever >100.4F (38C)	☐ Yes ☐ No ☐ Unknown	
Highest temp_____ °F		
Subjective fever (felt feverish)	☐ Yes ☐ No ☐ Unknown	
Chills	☐ Yes ☐ No ☐ Unknown	
Sweats	☐ Yes ☐ No ☐ Unknown	
Dehydration	☐ Yes ☐ No ☐ Unknown	
Cough (new onset or worsening of chronic cough)	☐ Yes ☐ No ☐ Unknown	
Dry	☐ Yes ☐ No ☐ Unknown	
Productive	☐ Yes ☐ No ☐ Unknown	
Bloody sputum (hemoptysis)	☐ Yes ☐ No ☐ Unknown	
Sore throat	☐ Yes ☐ No ☐ Unknown	
Wheezing	☐ Yes ☐ No ☐ Unknown	
Shortness of breath (dyspnea)	☐ Yes ☐ No ☐ Unknown	
Runny nose (rhinorrhea)	☐ Yes ☐ No ☐ Unknown	
Stuffy nose (nasal congestion)	☐ Yes ☐ No ☐ Unknown	
Loss of smell (Anosmia)	☐ Yes ☐ No ☐ Unknown	
Loss of taste (Ageusia)	☐ Yes ☐ No ☐ Unknown	
Swollen Lymph Nodes (Lymphadenopathy)	☐ Yes ☐ No ☐ Unknown	
Eye redness (conjunctivitis)	☐ Yes ☐ No ☐ Unknown	
Rash	☐ Yes ☐ No ☐ Unknown	
Abdominal pain	☐ Yes ☐ No ☐ Unknown	
Vomiting	☐ Yes ☐ No ☐ Unknown	
Nausea	☐ Yes ☐ No ☐ Unknown	
Loss of appetite (anorexia)	☐ Yes ☐ No ☐ Unknown	
Diarrhea (>3 loose stools/day)	☐ Yes ☐ No ☐ Unknown	
Chest Pain	☐ Yes ☐ No ☐ Unknown	
Muscle aches (myalgia)	☐ Yes ☐ No ☐ Unknown	
Joint Pain (Arthralgia)	☐ Yes ☐ No ☐ Unknown	

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Symptom	Symptom Present?	Date of Onset (MM/DD/YY)
Headache	☐ Yes ☐ No ☐ Unknown	
Fatigue	☐ Yes ☐ No ☐ Unknown	
Seizures	☐ Yes ☐ No ☐ Unknown	
Altered Mental Status (confusion)	☐ Yes ☐ No ☐ Unknown	
Other, specify:	☐ Yes ☐ No ☐ Unknown	
Other, specify:	☐ Yes ☐ No ☐ Unknown	
Other, specify:	☐ Yes ☐ No ☐ Unknown	
Other, specify:	☐ Yes ☐ No ☐ Unknown	

15. If the patient had a fever during this hospitalization (from presentation onward), what was the first date without documented fever:
_____/_____/_____ (MM/DD/YYYY)

16. Did the following events/complications occur in the course of hospitalization? *As reported by a physician in the medical record (e.g., notes).*

Shock	☐ Yes	☐ No	☐ Unknown
Volume overload	☐ Yes	☐ No	☐ Unknown
Pulmonary edema	☐ Yes	☐ No	☐ Unknown
Congestive heart failure	☐ Yes	☐ No	☐ Unknown
Cardiac arrhythmia	☐ Yes	☐ No	☐ Unknown
Myocardial infarction	☐ Yes	☐ No	☐ Unknown
Cardiac arrest	☐ Yes	☐ No	☐ Unknown
New onset cardiomyopathy	☐ Yes	☐ No	☐ Unknown
Myocarditis	☐ Yes	☐ No	☐ Unknown
Viral pneumonia	☐ Yes	☐ No	☐ Unknown
Acute Respiratory Distress Syndrome (ARDS)	☐ Yes	☐ No	☐ Unknown
If yes to ARDS, date of first ARDS diagnosis: _____/_____/_____ (MM/DD/YYYY)			
If yes to ARDS, severity:	☐ Mild	☐ Moderate	☐ Severe
COPD exacerbation	☐ Yes	☐ No	☐ Unknown
Asthma exacerbation	☐ Yes	☐ No	☐ Unknown
Pulmonary embolism	☐ Yes	☐ No	☐ Unknown
Gastrointestinal hemorrhage	☐ Yes	☐ No	☐ Unknown
Pancreatitis	☐ Yes	☐ No	☐ Unknown
Liver dysfunction	☐ Yes	☐ No	☐ Unknown
Acute kidney injury	☐ Yes	☐ No	☐ Unknown
Acute interstitial nephritis	☐ Yes	☐ No	☐ Unknown
Acute tubular necrosis	☐ Yes	☐ No	☐ Unknown
Meningitis/Encephalitis	☐ Yes	☐ No	☐ Unknown
Seizures	☐ Yes	☐ No	☐ Unknown
Stroke/Cerebrovascular accident CVA	☐ Yes	☐ No	☐ Unknown
Coagulation disorder/Disseminated Intravascular Coagulation (DIC)	☐ Yes	☐ No	☐ Unknown
Hemophagocytic syndrome	☐ Yes	☐ No	☐ Unknown

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Deep vein thrombosis (DVT)	☐ Yes	☐ No	☐ Unknown
Rhabdomyolysis	☐ Yes	☐ No	☐ Unknown
Myositis	☐ Yes	☐ No	☐ Unknown
Ventilator-acquired pneumonia (VAP)	☐ Yes	☐ No	☐ Unknown
Hospital-acquired pneumonia (HAP)	☐ Yes	☐ No	☐ Unknown
Multisystem organ failure	☐ Yes	☐ No	☐ Unknown
Sepsis	☐ Yes	☐ No	☐ Unknown
Bacterial co-infection	☐ Yes	☐ No	☐ Unknown
If Yes, specify: _____			
Viral co-infection	☐ Yes	☐ No	☐ Unknown
If Yes, specify: _____			
Fungal co-infection	☐ Yes	☐ No	☐ Unknown
If Yes, specify: _____			

17. During hospitalization, did the patient EVER receive…

		Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY) *(leave blank if still receiving)*	Total Days
Supplemental Oxygen via facemask?	☐ Y ☐ N ☐ Unk			
Supplemental Oxygen via low flow nasal cannula?	☐ Y ☐ N ☐ Unk			
High flow nasal cannula?	☐ Y ☐ N ☐ Unk			
Non-invasive ventilation (e.g., BiPaP)?	☐ Y ☐ N ☐ Unk			
Invasive mechanical ventilation (MV)?	☐ Y ☐ N ☐ Unk			
If yes to MV, highest FiO2		_____		
If yes to MV, lowest SpO2 at highest FiO2		_____ %		
If available, lowest SaO2 at highest FiO2		_____ %		
ECMO?	☐ Y ☐ N ☐ Unk			
Vasopressors? (ONLY if used to treat septic shock and not sedation-induced hypotension)	☐ Y ☐ N ☐ Unk			

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If yes, which vasopressor(s)? *(choose all that apply)*		☐ Dopamine ☐ Dobutamine ☐ Phenylephrine ☐ Norepinephrine ☐ Epinephrine ☐ Vasopressin		
NEW dialysis?	☐ Y ☐ N ☐ Unk			
If yes, was dialysis recommended to continue at discharge?		☐ Y ☐ N ☐ Unknown ☐ Patient died during hospitalization ☐ Patient still hospitalized		
Cardiopulmonary Rescuscitation (CPR)?	☐ Y ☐ N ☐ Unk	Date (of last attempt if multiple): _____/_____/_____		
Neuromuscular blocking agents?	☐ Y ☐ N ☐ Unk			
Prone positioning?	☐ Y ☐ N ☐ Unk			
Tracheostomy inserted?	☐ Y ☐ N ☐ Unk			
Plasmapherisis?	☐ Y ☐ N ☐ Unk			
IVIG?	☐ Y ☐ N ☐ Unk			

18. Was the patient admitted to an intensive care unit (ICU)? ☐ Yes ☐ No ☐ Unknown

ICU admission date 1 _____/_____/_____ (MM/DD/YYYY) ICU discharge date 1 _____/_____/_____ (MM/DD/YYYY) ☐ still in ICU

ICU admission date 2 _____/_____/_____ (MM/DD/YYYY) ICU discharge date 2 _____/_____/_____ (MM/DD/YYYY) ☐ still in ICU

19. For patients who were admitted to the intensive care unit (ICU): fill out the **Sequential Organ Failure Assessment (SOFA)** for each day in the ICU. If multiple values are available for a parameter for a given day, fill in the most abnormal value.

For the MAP (mean arterial pressure) OR administration of vasoactive agents required, please fill in **A-E** as follows:

A. Not hypotensive
B. MAP < 70 mmHg
C. DOPamine ≤ 5 ug/kg/min OR DOBUTamine (any dose)
D. DOPamine > 5 ug/kg/min OR EPINEPHrine ≤ 0.1 ug/kg/min OR norepinephrine ≤ 0.1 ug/kg/min
E. DOPamine > 15 ug/kg/min OR EPINEPHrine > 0.1 ug/kg/min OR norepinephrine > 0.1 ug/kg/min

For creatinine, mg/dL (umol/L) or urine output, please fill in **A-E** as follows:

A. <1.2 (<110)
B. 1.2-1.9 (110-170)
C. 2.0-3.4 (171-299)
D. 3.5-4.9 (300-400) OR UOP <500 mL/day
E. ≥5.0 (>440) OR UOP <200 mL/day

Date (MM/DD/YYYY)							
PaO2 (mmHg)							
FiO2 (0-1)							
Is pt on MV?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
PLT (10^3/uL)							
GCS							
Bilirubin (mg/dL)							
MAP OR vasoactive agents required							

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Creatinine or UOP							

**If more than 7 days in the ICU use additional SOFA tables at end of form*

20. QTc from final available EKG: _________ seconds

21. Clinical Discharge Diagnoses and ICD10 Discharge Codes

Clinical Discharge Diagnoses	ICD-10-CM Code
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

22. Was the patient discharged on any type of oxygen support? ☐ Yes ☐ No ☐ Unknown ☐ Patient died during hospitalization
Type of oxygen support: ☐ Intermittent NC ☐ Continuous NC ☐ Trach with intermittent oxygen ☐ Trach with continuous oxygen

23. List any medications listed in discharge summary in the table below: ☐ No medications at discharge

Medication Name	Route	Frequency
	☐ PO ☐ Injection ☐ Topical ☐ Inhaled ☐ Other _____________	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown ☐ Other _______________
	☐ PO ☐ Injection ☐ Topical ☐ Inhaled ☐ Other _____________	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown ☐ Other _______________
	☐ PO ☐ Injection ☐ Topical ☐ Inhaled ☐ Other _____________	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown ☐ Other _______________
	☐ PO ☐ Injection ☐ Topical ☐ Inhaled ☐ Other _____________	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown ☐ Other _______________
	☐ PO ☐ Injection ☐ Topical ☐ Inhaled ☐ Other _____________	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown ☐ Other _______________
	☐ PO ☐ Injection ☐ Topical ☐ Inhaled ☐ Other _____________	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown ☐ Other _______________

Laboratory Data

24. First recorded laboratory values for:

Test		Date of Collection (MM/DD/YYYY)	Value
Hematology CBC	☐ Not performed		
WBC (10^9/L)	☐ Not performed		

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Differential	☐ Not performed		
% Segmented neutrophils	☐ Not performed		
% Bands	☐ Not performed		
% Lymphocytes	☐ Not performed		
% Monocytes	☐ Not performed		
% Eosinophils	☐ Not performed		
% Basophils	☐ Not performed		
Absolute neutrophil count (10^3/mcL)	☐ Not performed		
Absolute lymphocyte count (10^3/mcL)	☐ Not performed		
Absolute eosinophils count (10^3/mcL)	☐ Not performed		
Hemoglobin (Hg) (gm/dL)	☐ Not performed		
Hematocrit (Hct) (%)	☐ Not performed		
Platelet Count (cells/mm^3)	☐ Not performed		
ANC (cells/mm^3)	☐ Not performed		
Ferritin (mg/mL)	☐ Not performed		
Chemistry - CMP/Chem 12	☐ Not performed		
Sodium (meq/L)	☐ Not performed		
Potassium (meq/L)	☐ Not performed		
Chloride (mmol/L)	☐ Not performed		
CO2 (mmol/L)	☐ Not performed		
Calcium (mg/dL)	☐ Not performed		
Phosphate (mg/dL)	☐ Not performed		
Magnesium (mg/dL)	☐ Not performed		
Glucose (mg/dL)	☐ Not performed		
BUN (mg/dL)	☐ Not performed		
Creatinine (mg/dL)	☐ Not performed		
AST (U/L)	☐ Not performed		
ALT (U/L)	☐ Not performed		
Alkaline Phosphatase (ALP) (U/L)	☐ Not performed		
Total Bilirubin (mg/dL)	☐ Not performed		
Total protein (g/dL)	☐ Not performed		
Albumin (g/L)	☐ Not performed		
Lactate dehydrogenase (LDH) (U/L)	☐ Not performed		
Creatinine Kinase (CK) (U/L)	☐ Not performed		
Blood Gas	☐ Not performed		☐ ABG ☐ VBG
pH	☐ Not performed		

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pCO2 (mmHg)	☐ Not performed		
pO2 (mmHg)	☐ Not performed		
HCO3 (mmol/L)	☐ Not performed		
Base Excess (mmol/L)	☐ Not performed		
If ABG, O2 Sat	☐ Not performed		
If ABG, FiO2	☐ Not performed		
Coagulation Panel	☐ Not performed		
PT (seconds)	☐ Not performed		
PTT (seconds)	☐ Not performed		
INR	☐ Not performed		
D dimer (mcg/mL)	☐ Not performed		
Fibrinogen	☐ Not performed		
Cardiac Biomarkers	☐ Not performed		
Troponin (ng/mL)	☐ Not performed		
BNP (pg/mL)	☐ Not performed		
Sepsis/Inflammatory Markers	☐ Not performed		
Lactate (mmol/L)	☐ Not performed		
Procalcitonin (ng/mL)	☐ Not performed		
CRP (mg/L)	☐ Not performed		
IL6 (pg/mL)	☐ Not performed		
Microbiology	☐ Not performed		
Rapid Strep (pos/neg)	☐ Not performed		
Legionella Urine Antigen	☐ Not performed		
Galactomannan	☐ Not performed		
Blood Bank	☐ Not performed		
Blood Type	☐ Not performed		
Rh status	☐ Not performed		

25. Most abnormal laboratory values for: ☐ No additional labs performed

Test		**Date of Collection (MM/DD/YYYY)**	**Value**
Hematology CBC	☐ Not performed		
WBC (10^9/L)	☐ Not performed		
Differential	☐ Not performed		
% Segmented neutrophils	☐ Not performed		
% Bands	☐ Not performed		
% Lymphocytes	☐ Not performed		
% Monocytes	☐ Not performed		

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% Eosinophils	☐ Not performed		
% Basophils	☐ Not performed		
Absolute neutrophil count (10^3/mcL)	☐ Not performed		
Absolute lymphocyte count (10^3/mcL)	☐ Not performed		
Absolute eosinophils count (10^3/mcL)	☐ Not performed		
Hemoglobin (Hg) (gm/dL)	☐ Not performed		
Hematocrit (Hct) (%)	☐ Not performed		
Platelet Count (cells/mm^3)	☐ Not performed		
ANC (cells/mm^3)	☐ Not performed		
Ferritin (mg/mL)	☐ Not performed		
Chemistry - CMP/Chem 12	☐ Not performed		
Sodium (meq/L)	☐ Not performed		
Potassium (meq/L)	☐ Not performed		
Chloride (mmol/L)	☐ Not performed		
CO2 (mmol/L)	☐ Not performed		
Calcium (mg/dL)	☐ Not performed		
Phosphate (mg/dL)	☐ Not performed		
Magnesium (mg/dL)	☐ Not performed		
Glucose (mg/dL)	☐ Not performed		
BUN (mg/dL)	☐ Not performed		
Creatinine (mg/dL)	☐ Not performed		
AST (U/L)	☐ Not performed		
ALT (U/L)	☐ Not performed		
Alkaline Phosphatase (ALP) (U/L)	☐ Not performed		
Total Bilirubin (mg/dL)	☐ Not performed		
Total protein (g/dL)	☐ Not performed		
Albumin (g/L)	☐ Not performed		
Lactate dehydrogenase (LDH) (U/L)	☐ Not performed		
Creatinine Kinase (CK) (U/L)	☐ Not performed		
Blood Gas	☐ Not performed		☐ ABG ☐ VBG
pH	☐ Not performed		
pCO2 (mmHg)	☐ Not performed		
pO2 (mmHg)	☐ Not performed		
HCO3 (mmol/L)	☐ Not performed		
Base Excess (mmol/L)	☐ Not performed		
If ABG, O2 Sat	☐ Not performed		

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If ABG, FiO2	☐ Not performed		
Coagulation Panel	☐ Not performed		
PT (seconds)	☐ Not performed		
PTT (seconds)	☐ Not performed		
INR	☐ Not performed		
D dimer (mcg/mL)	☐ Not performed		
Fibrinogen	☐ Not performed		
Cardiac Biomarkers	☐ Not performed		
Troponin (ng/mL)	☐ Not performed		
BNP (pg/mL)	☐ Not performed		
Sepsis/Inflammatory Markers	☐ Not performed		
Lactate (mmol/L)	☐ Not performed		
Procalcitonin (ng/mL)	☐ Not performed		
CRP (mg/L)	☐ Not performed		
IL6 (pg/mL)	☐ Not performed		

Treatment Data

26. Did the patient receive antibiotics within the first 48 hours of presentation? ☐ Yes ☐ No ☐ Unknown
27. Did the patient receive antibiotics after the first 48 hours of presentation? ☐ Yes ☐ No ☐ Unknown
28. Did the patient receive any of the following medications during treatment of this illness:

Medication		Route	Dosage (units)	Frequency	Start Date (MM/DD/YYYY)	Last Date (MM/DD/YYYY)
Remdesivir	☐ Y ☐ N ☐ Unk	☐ PO ☐ IV ☐ IM ☐ Other: _____				
If yes, remdesivir use:	☐ RCT ☐ Compassionate use ☐ Other trial					
Chloroquine	☐ Y ☐ N ☐ Unk	☐ PO ☐ IV ☐ IM ☐ Other: _____				
Hydroxychloroquine	☐ Y ☐ N ☐ Unk	☐ PO ☐ IV ☐ IM ☐ Other: _____				
Lopinavir/ritonavir	☐ Y ☐ N ☐ Unk	☐ PO ☐ IV ☐ IM ☐ Other: _____				
Oseltamivir	☐ Y ☐ N ☐ Unk	☐ PO ☐ IV ☐ IM ☐ Other: _____				
Baloxavir marboxil	☐ Y ☐ N ☐ Unk	☐ PO ☐ IV ☐ IM				

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		☐ Other: _____				
Ribavirin	☐ Y ☐ N ☐ Unk	☐ PO ☐ IV ☐ IM ☐ Other: _____				
Tocilizumab	☐ Y ☐ N ☐ Unk	☐ PO ☐ IV ☐ IM ☐ Other: _____				
Sarilumab	☐ Y ☐ N ☐ Unk	☐ PO ☐ IV ☐ IM ☐ Other: _____				
NSAIDs	☐ Y ☐ N ☐ Unk					
If yes, name: _____		☐ PO ☐ IV ☐ IM ☐ Other: _____				
Aspirin	☐ Y ☐ N ☐ Unk	☐ PO ☐ IV ☐ IM ☐ Other: _____				
Interferon Alpha	☐ Y ☐ N ☐ Unk	☐ PO ☐ IV ☐ IM ☐ Other: _____				
Interferon Beta	☐ Y ☐ N ☐ Unk	☐ PO ☐ IV ☐ IM ☐ Other: _____				
Azithromycin	☐ Y ☐ N ☐ Unk	☐ PO ☐ IV ☐ IM ☐ Other: _____				
Other antibiotics	☐ Y ☐ N ☐ Unk					
If yes, name: _____		☐ PO ☐ IV ☐ IM ☐ Other: _____				
If yes, name: _____		☐ PO ☐ IV ☐ IM ☐ Other: _____				
If yes, name: _____		☐ PO ☐ IV ☐ IM ☐ Other: _____				
If yes, name: _____		☐ PO ☐ IV ☐ IM ☐ Other: _____				
If yes, name: _____		☐ PO ☐ IV ☐ IM				

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		☐ Other: _____				
Systemic corticosteroids	☐ Y ☐ N ☐ Unk	☐ PO ☐ IV ☐ IM ☐ Other: _____				
Systemic Antifungals	☐ Y ☐ N ☐ Unk					
If yes, name: _____		☐ PO ☐ IV ☐ IM ☐ Other: _____				
If yes, name: _____		☐ PO ☐ IV ☐ IM ☐ Other: _____				
If yes, name: _____		☐ PO ☐ IV ☐ IM ☐ Other: _____				
Inhaled Nitrous Oxide	☐ Y ☐ N ☐ Unk	☐ PO ☐ IV ☐ IM ☐ Other: _____				
Epoprostenol (Flolan)	☐ Y ☐ N ☐ Unk	☐ PO ☐ IV ☐ IM ☐ Other: _____				
Other relevant treatment for this illness:_____	☐ Y ☐ N ☐ Unk	☐ PO ☐ IV ☐ IM ☐ Other: _____				
Other relevant treatment for this illness:_____	☐ Y ☐ N ☐ Unk	☐ PO ☐ IV ☐ IM ☐ Other: _____				

29. Was the patient in a clinical trial? ☐ Yes ☐ Not documented
    If yes, what medication/intervention: _____
    _____

Imaging

30. Was a chest x-ray taken? ☐ Yes ☐ No ☐ Unknown
31. Were any of these chest x-rays abnormal? ☐ Yes ☐ No ☐ Unknown
    Date of first abnormal chest x-ray: _____/_____/_____ (MM/DD/YYYY
32. For first abnormal chest x-ray, please check all that apply: Report not available: ☐

☐ Air space density	☐ Cannot rule out pneumonia	☐ ARDS (acute respiratory distress syndrome)	☐ Other
☐ Air space opacity	☐ Consolidation	☐ Lung infiltrate	☐ Pleural Effusion
☐ Bronchopneumonia/pneumonia	☐ Cavitation	☐ Interstitial infiltrate	☐ Empyema

    Additional radiologist findings for first abnormal chest x-ray: _____
    _____

33. Was a chest CT/MRI taken? ☐ Yes ☐ No ☐ Unknown

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34. Were any of these chest CT/MRIs abnormal? ☐ Yes ☐ No ☐ Unknown
Date of first abnormal CT/MRI: ______/_____/_______ (MM/DD/YYYY)

35. For first abnormal chest CT/MRI, please check all that apply: Report not available: ☐

☐ Air space density	☐ Cavitation	☐ Empyema	☐ Englarged epiglottis
☐ Air space opacity/opacification	☐ Lung infiltrate	☐ Pneumothorax	☐ Tracheal narrowing
☐ ARDS (acute respiratory distress syndrome)	☐ Interstitial infiltrate	☐ Pneumomediastinum	☐ Ground glass opacities
☐ Bronchopneumonia/pneumonia	☐ Lobar infiltrate	☐ Widened mediastinum	☐ Cannot rule out pneumonia
☐ Consolidation	☐ Pleural effusion	☐ Pulmonary Edema	☐ Other

Additional radiologist findings for first abnormal chest CT/MRI: ____
____

Infectious Disease Testing

36. SARS-CoV-2 Testing (Please report further test results in comments)

Date of sample collection (MM/DD/YYYY)	Sample Type	Result	CT Value
	☐ NP ☐ OP ☐ Sputum ☐ Other, specify: ________________	☐ Pos ☐ Neg ☐ Inconclusive	_________ ☐ not available
	☐ NP ☐ OP ☐ Sputum ☐ Other, specify: ________________	☐ Pos ☐ Neg ☐ Inconclusive	_________ ☐ not available
	☐ NP ☐ OP ☐ Sputum ☐ Other, specify: ________________	☐ Pos ☐ Neg ☐ Inconclusive	_________ ☐ not available
	☐ NP ☐ OP ☐ Sputum ☐ Other, specify: ________________	☐ Pos ☐ Neg ☐ Inconclusive	_________ ☐ not available
	☐ NP ☐ OP ☐ Sputum ☐ Other, specify: ________________	☐ Pos ☐ Neg ☐ Inconclusive	_________ ☐ not available

37. Was patient tested for other viral respiratory pathogens during their illness? ☐ Yes (report results below) ☐ No ☐ Unknown

	Positive	Negative	Not Tested/ Unknown	Collection Date (MM/DD/YYY)	Specimen Type
Flu A	☐	☐	☐	____/____/________	
Flu A H1	☐	☐	☐	____/____/________	
Flu A H3/H3N2	☐	☐	☐	____/____/________	
Flu B	☐	☐	☐	____/____/________	
Flu (no type)	☐	☐	☐		
Respiratory syncytial virus/RSV	☐	☐	☐	____/____/________	
Adenovirus	☐	☐	☐	____/____/________	
Parainfluenza virus 1	☐	☐	☐	____/____/________	

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Parainfluenza virus 2	☐	☐	☐	____/____/_____	
Parainfluenza virus 3	☐	☐	☐	____/____/_____	
Parainfluenza virus 4	☐	☐	☐	____/____/_____	
Respiratory syncytial virus/RSV	☐	☐	☐	____/____/_____	
Human metapneumovirus	☐	☐	☐	____/____/_____	
Rhinovirus/enterovirus	☐	☐	☐	____/____/_____	
Human coronavirus 229E	☐	☐	☐	____/____/_____	
Human coronavirus HKU1	☐	☐	☐	____/____/_____	
Human coronavirus NL63	☐	☐	☐	____/____/_____	
Human coronavirus OC43	☐	☐	☐	____/____/_____	
Other, specify: _____	☐	☐	☐	____/____/_____	

38. Were any bacterial culture tests performed during their illness? ☐ Yes ☐ No ☐ Unknown
If yes, was there a positive culture for a bacterial pathogen? ☐ Yes ☐ No ☐ Unknown
If yes, specify pathogen: _____

If yes, specify date of culture (MM/DD/YYYY): _____

If yes, site where pathogen identified: ☐ Blood ☐ Sputum ☐ Throat swab ☐ Bronchoalveolar lavage (BAL) ☐ Endotracheal aspirate ☐ Pleural fluid ☐ Cerebrospinal fluid (CSF) ☐ Other, specify: _____
If more than one bacterial culture test was performed, please record in additional comments.

39. Were any fungal culture tests performed during their illness? ☐ Yes ☐ No ☐ Unknown
If yes, was there a positive culture for a fungal pathogen? ☐ Yes ☐ No ☐ Unknown
If yes, specify pathogen: _____

If yes, specify date of culture (MM/DD/YYYY): _____

If yes, site where pathogen identified: ☐ Blood ☐ Sputum ☐ Bronchoalveolar lavage (BAL) ☐ Endotracheal aspirate ☐ Pleural fluid ☐ Cerebrospinal fluid (CSF) ☐ Other, specify: _____
If more than one fungal culture test was performed, please record in additional comments.

Outcome

40. Did the patient die as a result of this illness?
☐ Yes, Date: _____/_____/_____ (MM/DD/YYYY) ☐ No ☐ Unknown
Where did the death occur: ☐ Home ☐ Hospital ☐ ER ☐ Hospice ☐ Other, specify_____
Was autopsy performed? ☐ Yes ☐ No ☐ Unknown

(If the following information is not currently available, please send an update later using death certificate or death note in hospital record.)
Contribution of COVID-19 to death ☐ Underlying/primary ☐ Contributing/secondary ☐ No contribution to death ☐ Unknown
Primary Cause of death (death certificate/coroner) _____
ICD-10-CM Cause of Death (for multiple codes, separate by semi-colon): _____

_____

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Additional SOFA Tables

Date (MM/DD/YYYY)							
PaO2 (mmHg)							
FiO2 (0-1)							
Is pt on MV?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
PLT (10^3/uL)							
GCS							
Bilirubin (mg/dL)							
MAP OR vasoactive agents required							
Creatinine or UOP							

Date (MM/DD/YYYY)							
PaO2 (mmHg)							
FiO2 (0-1)							
Is pt on MV?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
PLT (10^3/uL)							
GCS							
Bilirubin (mg/dL)							
MAP OR vasoactive agents required							
Creatinine or UOP							

Additional Medications

Medication Name	Route	Frequency	Time period
	☐ PO ☐ Injection ☐ Topical ☐ Inhaled ☐ Other ________	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown ☐ Other ________	☐ Prior to admission ☐ During adminssion ☐ At discharge
	☐ PO ☐ Injection ☐ Topical ☐ Inhaled ☐ Other ________	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown ☐ Other ________	☐ Prior to admission ☐ During adminssion ☐ At discharge
	☐ PO ☐ Injection ☐ Topical ☐ Inhaled ☐ Other ________	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown ☐ Other ________	☐ Prior to admission ☐ During adminssion ☐ At discharge
	☐ PO ☐ Injection ☐ Topical ☐ Inhaled ☐ Other ________	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown ☐ Other ________	☐ Prior to admission ☐ During adminssion ☐ At discharge
	☐ PO ☐ Injection ☐ Topical ☐ Inhaled ☐ Other ________	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown ☐ Other ________	☐ Prior to admission ☐ During adminssion ☐ At discharge
	☐ PO ☐ Injection ☐ Topical ☐ Inhaled ☐ Other ________	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown ☐ Other ________	☐ Prior to admission ☐ During adminssion

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			☐ At discharge

Any additional comments or notes?