

.....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)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Highest temp _____ °F		
Subjective fever (felt feverish)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Dehydration	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	



## COVID-19 Case Chart Abstraction Form

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



## COVID-19 Case Chart Abstraction Form

	Indication: _____		
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Indication: _____		
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Indication: _____		
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Indication: _____		
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Emphysema/Chronic Obstructive Pulmonary Disease (COPD)/Chronic Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Interstitial lung disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Pulmonary fibrosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown



## COVID-19 Case Chart Abstraction Form

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



## COVID-19 Case Chart Abstraction Form

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



## COVID-19 Case Chart Abstraction Form

Radiation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year(s): _____
Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year(s): _____
<b>Neurologic/neurodevelopmental disorder: do you have any diseases of the brain, spinal cord, or nerves?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
If Yes, specify: _____				
<b>Psychiatric Diagnosis: do you have any mental health problems? (e.g. depression, bipolar disorder, anxiety disorder, schizophrenia)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
If Yes, specify: _____				
<b>Other chronic diseases:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Highest temp _____ °F		
Subjective fever (felt feverish)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Dehydration	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Cough (new onset or worsening of chronic cough)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Dry	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Productive	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Bloody sputum (hemoptysis)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Shortness of breath (dyspnea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Runny nose (rhinorrhea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Stuffy nose (nasal congestion)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Loss of smell (Anosmia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Loss of taste (Ageusia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Swollen Lymph Nodes (Lymphadenopathy)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Eye redness (conjunctivitis)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Loss of appetite (anorexia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Diarrhea (>3 loose stools/day)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Muscle aches (myalgia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Joint Pain (Arthralgia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	



## COVID-19 Case Chart Abstraction Form

Symptom	Symptom Present?	Date of Onset (MM/DD/YY)
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Altered Mental Status (confusion)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Other, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Other, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Other, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Other, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Volume overload	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Pulmonary edema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Congestive heart failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Cardiac arrhythmia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Myocardial infarction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Cardiac arrest	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
New onset cardiomyopathy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Myocarditis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Viral pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Acute Respiratory Distress Syndrome (ARDS)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If yes to ARDS, date of first ARDS diagnosis: ____/____/____ (MM/DD/YYYY)			
If yes to ARDS, severity:		<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate <input type="checkbox"/> Severe
COPD exacerbation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Asthma exacerbation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Pulmonary embolism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Gastrointestinal hemorrhage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Pancreatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Liver dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Acute kidney injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Acute interstitial nephritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Acute tubular necrosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Meningitis/Encephalitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Stroke/Cerebrovascular accident CVA	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Coagulation disorder/Disseminated Intravascular Coagulation (DIC)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Hemophagocytic syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown



## COVID-19 Case Chart Abstraction Form

Deep vein thrombosis (DVT)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Rhabdomyolysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Myositis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Ventilator-acquired pneumonia (VAP)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Hospital-acquired pneumonia (HAP)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Multisystem organ failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Sepsis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Bacterial co-infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If Yes, specify: _____			
Viral co-infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If Yes, specify: _____			
Fungal co-infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If Yes, specify: _____			

17. During hospitalization, did the patient EVER receive...

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





## COVID-19 Case Chart Abstraction Form

If yes, which vasopressor(s)? <i>(choose all that apply)</i>	<input type="checkbox"/> Dopamine <input type="checkbox"/> Dobutamine <input type="checkbox"/> Phenylephrine <input type="checkbox"/> Norepinephrine <input type="checkbox"/> Epinephrine <input type="checkbox"/> Vasopressin
NEW dialysis? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
If yes, was dialysis recommended to continue at discharge?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/> Patient died during hospitalization <input type="checkbox"/> Patient still hospitalized
Cardiopulmonary Resuscitation (CPR)? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	Date (of last attempt if multiple): _____/_____/_____
Neuromuscular blocking agents? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
Prone positioning? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
Tracheostomy inserted? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
Plasmapheresis? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
IVIG? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
PLT (10 <sup>3</sup> /uL)							
GCS							
Bilirubin (mg/dL)							
MAP <u>OR</u> vasoactive agents required							



## COVID-19 Case Chart Abstraction Form

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
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____

### Laboratory Data

24. First recorded laboratory values for:

Test		Date of Collection (MM/DD/YYYY)	Value
<b>Hematology CBC</b>	<input type="checkbox"/> Not performed		
WBC (10 <sup>9</sup> /L)	<input type="checkbox"/> Not performed		



## COVID-19 Case Chart Abstraction Form

<b>Differential</b>	<input type="checkbox"/> Not performed		
% Segmented neutrophils	<input type="checkbox"/> Not performed		
% Bands	<input type="checkbox"/> Not performed		
% Lymphocytes	<input type="checkbox"/> Not performed		
% Monocytes	<input type="checkbox"/> Not performed		
% Eosinophils	<input type="checkbox"/> Not performed		
% Basophils	<input type="checkbox"/> Not performed		
Absolute neutrophil count ( $10^3/\text{mCL}$ )	<input type="checkbox"/> Not performed		
Absolute lymphocyte count ( $10^3/\text{mCL}$ )	<input type="checkbox"/> Not performed		
Absolute eosinophils count ( $10^3/\text{mCL}$ )	<input type="checkbox"/> Not performed		
Hemoglobin (Hg) (gm/dL)	<input type="checkbox"/> Not performed		
Hematocrit (Hct) (%)	<input type="checkbox"/> Not performed		
Platelet Count (cells/ $\text{mm}^3$ )	<input type="checkbox"/> Not performed		
<b>ANC (cells/<math>\text{mm}^3</math>)</b>	<input type="checkbox"/> Not performed		
<b>Ferritin (mg/mL)</b>	<input type="checkbox"/> Not performed		
<b><u>Chemistry - CMP/Chem 12</u></b>	<input type="checkbox"/> Not performed		
Sodium (meq/L)	<input type="checkbox"/> Not performed		
Potassium (meq/L)	<input type="checkbox"/> Not performed		
Chloride (mmol/L)	<input type="checkbox"/> Not performed		
CO <sub>2</sub> (mmol/L)	<input type="checkbox"/> Not performed		
Calcium (mg/dL)	<input type="checkbox"/> Not performed		
Phosphate (mg/dL)	<input type="checkbox"/> Not performed		
Magnesium (mg/dL)	<input type="checkbox"/> Not performed		
Glucose (mg/dL)	<input type="checkbox"/> Not performed		
BUN (mg/dL)	<input type="checkbox"/> Not performed		
Creatinine (mg/dL)	<input type="checkbox"/> Not performed		
AST (U/L)	<input type="checkbox"/> Not performed		
ALT (U/L)	<input type="checkbox"/> Not performed		
Alkaline Phosphatase (ALP) (U/L)	<input type="checkbox"/> Not performed		
Total Bilirubin (mg/dL)	<input type="checkbox"/> Not performed		
Total protein (g/dL)	<input type="checkbox"/> Not performed		
Albumin (g/L)	<input type="checkbox"/> Not performed		
Lactate dehydrogenase (LDH) (U/L)	<input type="checkbox"/> Not performed		
Creatinine Kinase (CK) (U/L)	<input type="checkbox"/> Not performed		
<b>Blood Gas</b>	<input type="checkbox"/> Not performed		<input type="checkbox"/> ABG <input type="checkbox"/> VBG
pH	<input type="checkbox"/> Not performed		



## COVID-19 Case Chart Abstraction Form

pCO <sub>2</sub> (mmHg)	<input type="checkbox"/> Not performed		
pO <sub>2</sub> (mmHg)	<input type="checkbox"/> Not performed		
HCO <sub>3</sub> (mmol/L)	<input type="checkbox"/> Not performed		
Base Excess (mmol/L)	<input type="checkbox"/> Not performed		
If ABG, O <sub>2</sub> Sat	<input type="checkbox"/> Not performed		
If ABG, FiO <sub>2</sub>	<input type="checkbox"/> Not performed		
<b><u>Coagulation Panel</u></b>	<input type="checkbox"/> Not performed		
PT (seconds)	<input type="checkbox"/> Not performed		
PTT (seconds)	<input type="checkbox"/> Not performed		
INR	<input type="checkbox"/> Not performed		
<b><u>D dimer (mcg/mL)</u></b>	<input type="checkbox"/> Not performed		
<b><u>Fibrinogen</u></b>	<input type="checkbox"/> Not performed		
<b><u>Cardiac Biomarkers</u></b>	<input type="checkbox"/> Not performed		
Troponin (ng/mL)	<input type="checkbox"/> Not performed		
BNP (pg/mL)	<input type="checkbox"/> Not performed		
<b><u>Sepsis/Inflammatory Markers</u></b>	<input type="checkbox"/> Not performed		
Lactate (mmol/L)	<input type="checkbox"/> Not performed		
Procalcitonin (ng/mL)	<input type="checkbox"/> Not performed		
CRP (mg/L)	<input type="checkbox"/> Not performed		
IL6 (pg/mL)	<input type="checkbox"/> Not performed		
<b><u>Microbiology</u></b>	<input type="checkbox"/> Not performed		
Rapid Strep (pos/neg)	<input type="checkbox"/> Not performed		
Legionella Urine Antigen	<input type="checkbox"/> Not performed		
Galactomannan	<input type="checkbox"/> Not performed		
<b><u>Blood Bank</u></b>	<input type="checkbox"/> Not performed		
Blood Type	<input type="checkbox"/> Not performed		
Rh status	<input type="checkbox"/> Not performed		

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

Test		Date of Collection (MM/DD/YYYY)	Value
<b><u>Hematology CBC</u></b>	<input type="checkbox"/> Not performed		
WBC (10 <sup>9</sup> /L)	<input type="checkbox"/> Not performed		
<b><u>Differential</u></b>	<input type="checkbox"/> Not performed		
% Segmented neutrophils	<input type="checkbox"/> Not performed		
% Bands	<input type="checkbox"/> Not performed		
% Lymphocytes	<input type="checkbox"/> Not performed		
% Monocytes	<input type="checkbox"/> Not performed		



## COVID-19 Case Chart Abstraction Form

% Eosinophils	<input type="checkbox"/> Not performed		
% Basophils	<input type="checkbox"/> Not performed		
Absolute neutrophil count (10 <sup>3</sup> /mCL)	<input type="checkbox"/> Not performed		
Absolute lymphocyte count (10 <sup>3</sup> /mCL)	<input type="checkbox"/> Not performed		
Absolute eosinophils count (10 <sup>3</sup> /mCL)	<input type="checkbox"/> Not performed		
Hemoglobin (Hg) (gm/dL)	<input type="checkbox"/> Not performed		
Hematocrit (Hct) (%)	<input type="checkbox"/> Not performed		
Platelet Count (cells/mm <sup>3</sup> )	<input type="checkbox"/> Not performed		
<b>ANC (cells/mm<sup>3</sup>)</b>	<input type="checkbox"/> Not performed		
<b>Ferritin (mg/mL)</b>	<input type="checkbox"/> Not performed		
<b><u>Chemistry - CMP/Chem 12</u></b>	<input type="checkbox"/> Not performed		
Sodium (meq/L)	<input type="checkbox"/> Not performed		
Potassium (meq/L)	<input type="checkbox"/> Not performed		
Chloride (mmol/L)	<input type="checkbox"/> Not performed		
CO <sub>2</sub> (mmol/L)	<input type="checkbox"/> Not performed		
Calcium (mg/dL)	<input type="checkbox"/> Not performed		
Phosphate (mg/dL)	<input type="checkbox"/> Not performed		
Magnesium (mg/dL)	<input type="checkbox"/> Not performed		
Glucose (mg/dL)	<input type="checkbox"/> Not performed		
BUN (mg/dL)	<input type="checkbox"/> Not performed		
Creatinine (mg/dL)	<input type="checkbox"/> Not performed		
AST (U/L)	<input type="checkbox"/> Not performed		
ALT (U/L)	<input type="checkbox"/> Not performed		
Alkaline Phosphatase (ALP) (U/L)	<input type="checkbox"/> Not performed		
Total Bilirubin (mg/dL)	<input type="checkbox"/> Not performed		
Total protein (g/dL)	<input type="checkbox"/> Not performed		
Albumin (g/L)	<input type="checkbox"/> Not performed		
Lactate dehydrogenase (LDH) (U/L)	<input type="checkbox"/> Not performed		
Creatinine Kinase (CK) (U/L)	<input type="checkbox"/> Not performed		
<b>Blood Gas</b>	<input type="checkbox"/> Not performed		<input type="checkbox"/> ABG <input type="checkbox"/> VBG
pH	<input type="checkbox"/> Not performed		
pCO <sub>2</sub> (mmHg)	<input type="checkbox"/> Not performed		
pO <sub>2</sub> (mmHg)	<input type="checkbox"/> Not performed		
HCO <sub>3</sub> (mmol/L)	<input type="checkbox"/> Not performed		
Base Excess (mmol/L)	<input type="checkbox"/> Not performed		
If ABG, O <sub>2</sub> Sat	<input type="checkbox"/> Not performed		



## COVID-19 Case Chart Abstraction Form

If ABG, FiO2	<input type="checkbox"/> Not performed				
<b>Coagulation Panel</b>	<input type="checkbox"/> Not performed				
PT (seconds)	<input type="checkbox"/> Not performed				
PTT (seconds)	<input type="checkbox"/> Not performed				
INR	<input type="checkbox"/> Not performed				
<b>D dimer (mcg/mL)</b>	<input type="checkbox"/> Not performed				
<b>Fibrinogen</b>	<input type="checkbox"/> Not performed				
<b>Cardiac Biomarkers</b>	<input type="checkbox"/> Not performed				
Troponin (ng/mL)	<input type="checkbox"/> Not performed				
BNP (pg/mL)	<input type="checkbox"/> Not performed				
<b>Sepsis/Inflammatory Markers</b>	<input type="checkbox"/> Not performed				
Lactate (mmol/L)	<input type="checkbox"/> Not performed				
Procalcitonin (ng/mL)	<input type="checkbox"/> Not performed				
CRP (mg/L)	<input type="checkbox"/> Not performed				
IL6 (pg/mL)	<input type="checkbox"/> 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	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> Other: _____				
If yes, remdesivir use:		<input type="checkbox"/> RCT <input type="checkbox"/> Compassionate use <input type="checkbox"/> Other trial				
Chloroquine	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> Other: _____				
Hydroxychloroquine	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> Other: _____				
Lopinavir/ritonavir	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> Other: _____				
Oseltamivir	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> Other: _____				
Baloxavir marboxil	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM				





## COVID-19 Case Chart Abstraction Form

		<input type="checkbox"/> Other: _____			
Systemic corticosteroids	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> Other: _____			
Systemic Antifungals	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk				
If yes, name: _____		<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> Other: _____			
If yes, name: _____		<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> Other: _____			
If yes, name: _____		<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> Other: _____			
Inhaled Nitrous Oxide	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> Other: _____			
Epoprostenol (Flolan)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> Other: _____			
Other relevant treatment for this illness: _____	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> Other: _____			
Other relevant treatment for this illness: _____	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> 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:

<input type="checkbox"/> Air space density	<input type="checkbox"/> Cannot rule out pneumonia	<input type="checkbox"/> ARDS (acute respiratory distress syndrome)	<input type="checkbox"/> Other
<input type="checkbox"/> Air space opacity	<input type="checkbox"/> Consolidation	<input type="checkbox"/> Lung infiltrate	<input type="checkbox"/> Pleural Effusion
<input type="checkbox"/> Bronchopneumonia/pneumonia	<input type="checkbox"/> Cavitation	<input type="checkbox"/> Interstitial infiltrate	<input type="checkbox"/> Empyema

Additional radiologist findings for first abnormal chest x-ray: \_\_\_\_\_

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





## COVID-19 Case Chart Abstraction Form

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:

<input type="checkbox"/> Air space density	<input type="checkbox"/> Cavitation	<input type="checkbox"/> Emphyema	<input type="checkbox"/> Enlarged epiglottis
<input type="checkbox"/> Air space opacity/opacification	<input type="checkbox"/> Lung infiltrate	<input type="checkbox"/> Pneumothorax	<input type="checkbox"/> Tracheal narrowing
<input type="checkbox"/> ARDS (acute respiratory distress syndrome)	<input type="checkbox"/> Interstitial infiltrate	<input type="checkbox"/> Pneumomediastinum	<input type="checkbox"/> Ground glass opacities
<input type="checkbox"/> Bronchopneumonia/pneumonia	<input type="checkbox"/> Lobar infiltrate	<input type="checkbox"/> Widened mediastinum	<input type="checkbox"/> Cannot rule out pneumonia
<input type="checkbox"/> Consolidation	<input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Pulmonary Edema	<input type="checkbox"/> 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
	<input type="checkbox"/> NP <input type="checkbox"/> OP <input type="checkbox"/> Sputum <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Inconclusive	_____ <input type="checkbox"/> not available
	<input type="checkbox"/> NP <input type="checkbox"/> OP <input type="checkbox"/> Sputum <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Inconclusive	_____ <input type="checkbox"/> not available
	<input type="checkbox"/> NP <input type="checkbox"/> OP <input type="checkbox"/> Sputum <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Inconclusive	_____ <input type="checkbox"/> not available
	<input type="checkbox"/> NP <input type="checkbox"/> OP <input type="checkbox"/> Sputum <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Inconclusive	_____ <input type="checkbox"/> not available
	<input type="checkbox"/> NP <input type="checkbox"/> OP <input type="checkbox"/> Sputum <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Inconclusive	_____ <input type="checkbox"/> 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/YYYY)	Specimen Type
Flu A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	
Flu A H1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	
Flu A H3/H3N2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	
Flu B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	
Flu (no type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Respiratory syncytial virus/RSV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	
Adenovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	
Parainfluenza virus 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	



## COVID-19 Case Chart Abstraction Form

Parainfluenza virus 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Parainfluenza virus 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Parainfluenza virus 4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Respiratory syncytial virus/RSV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Human metapneumovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Rhinovirus/enterovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Human coronavirus 229E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Human coronavirus HKU1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Human coronavirus NL63	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Human coronavirus OC43	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	

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): \_\_\_\_\_



Record ID: CO \_\_\_\_\_

## COVID-19 Case Chart Abstraction Form

### Additional SOFA Tables

Date (MM/DD/YYYY)							
PaO2 (mmHg)							
FiO2 (0-1)							
Is pt on MV?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
PLT (10 <sup>3</sup> /uL)							
GCS							
Bilirubin (mg/dL)							
MAP <u>OR</u> vasoactive agents required							
Creatinine or UOP							

Date (MM/DD/YYYY)							
PaO2 (mmHg)							
FiO2 (0-1)							
Is pt on MV?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
PLT (10 <sup>3</sup> /uL)							
GCS							
Bilirubin (mg/dL)							
MAP <u>OR</u> vasoactive agents required							
Creatinine or UOP							

### Additional Medications

Medication Name	Route	Frequency	Time period
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Prior to admission <input type="checkbox"/> During admnssion <input type="checkbox"/> At discharge
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Prior to admission <input type="checkbox"/> During admnssion <input type="checkbox"/> At discharge
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Prior to admission <input type="checkbox"/> During admnssion <input type="checkbox"/> At discharge
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Prior to admission <input type="checkbox"/> During admnssion <input type="checkbox"/> At discharge
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Prior to admission <input type="checkbox"/> During admnssion <input type="checkbox"/> At discharge
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Prior to admission <input type="checkbox"/> During admnssion



Record ID: CO\_\_\_\_\_

# COVID-19 Case Chart Abstraction Form

			<input type="checkbox"/> At discharge
--	--	--	---------------------------------------

Any additional comments or notes?