Supplementary material

Patient - Case Report Form
NOSO-COR project
Version 3

Date of reporting to national health authority: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]
Reporting institution: _____
Reporting country:_____
Case classification: ▫ Confirmed ▫ Suspected
Detected at admission ▫ No ▫ Yes ▫ Unknown If yes, date [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Section 1: Patient information

Unique Case Identifier (used in country): : [_ _][_ _] [_ _][_ _] [_ _][_ _] [_ _][_ _][_ _][_ _]

Date of Birth: [_M_][_M_]/[_Y_][_Y_][_Y_][_Y_] or estimated age: [___][___][___] in years

if < **1** year old, [___][___] in months or if < **1** month, [___][___] in days
Sex at birth: ▫ Male ▫ Female
Weight (Kg) [___][___][___] Height (cm) [___][___][___][___]
Place where the case was diagnosed: Country: _____
Admin Level **1** (province): _____ Admin Level 2 (district): _____
Patient usual place of residency: Country: _____
Admin Level **1** (province): _____ Admin Level 2 (district): _____

Section 2: Clinical information

Patient clinical course
Date of onset of symptoms: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_] ▫ Unknown
Admission to hospital: ▫ No ▫ Yes ▫ Unknown
First date of admission to hospital: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]
Name of hospital: _____

Hospitalization in ICU at admission ▫ No ▫ Yes ▫ Unknown
If Yes, date of ICU hospitalization [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]
Date of discharge from ICU [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Hospitalization in ICU during hospital stay ▫ No ▫ Yes ▫ Unknown
If Yes, date of ICU hospitalization during stay [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]
Date of discharge from ICU [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Was the patient ventilated: ▫ No ▫ Yes ▫ Unknown
If Yes, date of start of ventilation [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]
Date of end of ventilation [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Date of discharge from Hospital [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Date of isolation: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Health status (circle) at time of reporting: recovered / not recovered / death / unknown

End date of symptoms: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_] ▫ Unknown

Complications after the event: ▫ Cardiac ▫ Respiratory ▫ Death ▫ No complication
▫ Unknown ▫ Pulmonary bacterial superinfection
▫ Other bacterial superinfection
▫ Cardiopulmonary Resuscitation
▫ Other: _____

Death ▫ No ▫ Yes ▫ Unknown
Date of death, if applicable: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

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Patient symptoms at admission (for community acquired cases) / at suspicion (for nosocomial cases)
(check all reported symptoms):

▫ History of fever / chills	▫ Shortness of breath	▫ Pain (check all that apply)
▫ General weakness	▫ Diarrhoea	*( ) Muscular ( ) Chest*
▫ Cough	▫ Nausea/vomiting	*( ) Abdominal ( ) Joint*
▫ Sore throat	▫ Headache	
▫ Runny nose	▫ Irritability/Confusion	
▫ Anosmia	▫ Ageusia	

▫ Other, specify _____

Patient signs:
Temperature at admission/at suspicion: [__][__][__] ▫°C / ▫ F Unknown ▫
Check all observed signs seen at least once during hospitalization:

▫ Pharyngeal exudate	▫ Coma	Lung X-ray: ▫ Yes ▫ No
▫ Conjunctival injection	▫ Dyspnoea / tachypnoea	If Yes: ▫ Abnormal lung X-ray finding
▫ Seizure	▫ Abnormal lung auscultation	

▫ Other, specify: _____

Underlying conditions and comorbidity at admission (check all that apply):

▫ Pregnancy (trimester: _____)	▫ Post-partum (< 6 weeks)
▫ Cardiovascular disease,	▫ Immunodeficiency, including HIV
▫ Hypertension	▫ Heart failure
▫ Diabetes	▫ Renal disease
▫ Liver disease	▫ Chronic lung disease
▫ Chronic neurological or neuromuscular disease	▫ Asthma
▫ Hypothyroidism	▫ COPD
▫ Malignancy	▫ Emphysema
▫ Rheumatic disease	▫ Chronic bronchitis

▫ Other, specify: _____

Smoking status
▫ Current smoker ▫ Ex-smoker, If Yes, Quit date [_Y_][_Y_][_Y_][_Y_] ▫ Never ▫ Data not available
Alcohol consumption: ▫ Daily ▫ Weekly ▫ Occasionally ▫ Never ▫ Data not available

Section 3: Exposure in the 14 days prior to symptom onset (prior to reporting if asymptomatic)

Occupation: (tick any that apply)

▫ Student	▫ Health care worker	▫ Other, specify: _____
▫ Working with animals	▫ Health laboratory worker	

Has the patient **visited any health care facility(ies)** in the 14 days prior to symptom onset? ▫ No ▫ Yes ▫ Unknown

Has the patient had **close contact**[1] with a person with acute respiratory infection in the 14 days prior to symptom onset?
▫ No ▫ Yes ▫ Unknown
If yes, contact setting (check all that apply):
▫ Health care setting ▫ Family setting ▫ Work place ▫ Unknown ▫ Other, specify: _____

Has the patient **had contact with a probable or confirmed case** in the 14 days prior to symptom onset? :
▫ No ▫ Yes ▫ Unknown
If yes, please list unique case identifiers of all probable or confirmed cases:
Case 1 identifier. _____ Case 2 identifier. _____ Case 3 identifier. _____
If yes, contact setting (check all that apply):
▫ Health care setting ▫ Family setting ▫ Work place ▫ Unknown ▫ Other, specify: _____
If yes, location/city/country for exposure: _____

Has the patient visited any **live animal markets** in the 14 days prior to symptom onset? ▫ No ▫ Yes ▫ Unknown
If yes, location/city/country for exposure: _____

[1] **Close contact**' is defined as:
- Health care associated exposure, including providing direct care to SARS-CoV-2 patients, working with health care workers infected with novel coronavirus, visiting patients or staying in the same close environment of a SARS-CoV-2 patient.
- Working together in close proximity or sharing the same classroom environment with a with a SARS-CoV-2 patient.
- Traveling together with SARS-CoV-2 patient in any kind of conveyance.
- Living in the same household as a SARS-CoV-2 patient

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Section 4: Laboratory information

Nasopharyngeal sample taken: Yes ☐ No ☐ If yes, date: _ _ / _ _ / _ _ _ Time (1 to 12): _____ ▫ AM (before noon) ▫ PM (after noon)

Name of confirming laboratory: _____

Date of laboratory confirmation: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_] Time (1 to 12): _____ ▫ AM (before noon) ▫ PM (after noon)

Please specify which assay was used: _____

Result: SARS-CoV-2 positive ☐ SARS-CoV-2 negative ☐ Other respiratory virus tested: Yes ☐ No ☐

If Yes, Influenza A (no sub-type) ☐ Influenza A(H1N1) $_{pdm09}$ ☐ Influenza A(H3N2) ☐ Influenza B (no sub-type) ☐

Influenza B/Yamagata ☐ Influenza B/Victoria ☐ RSV ☐ Other virus (_____) ☐ No virus ☐

Sequencing done will be?: Yes ☐ No ☐ Unknown ☐

Several nasopharyngeal sample taken during hospitalization: Yes ☐ No ☐

If yes, date of first negative test: _ _ / _ _ / _ _ _

Section 5: Information regarding hospitalization* (NOSO-COR Project)

Specificity of the ward at inclusion: ▫ ICU ▫ Surgery ▫ Medicine ▫ Obstetrics ▫ Other: _____

Number of rooms in the ward; _____ Number of beds in the ward: _____

ID (or name) of the ward: _____ Room N°: _____

▫ Single room

▫ Double room If yes, roommate ▫ Present ▫ Absent

▫ More than 2 beds in the room, If yes, number of beds: _____ number of present roommate: _____

Did the patient move to other type of room during hospitalization? ▫ Yes ▫ No

▫ Single room

▫ Double room If yes, roommate ▫ Present ▫ Absent

▫ More than 2 beds in the room, If yes, number of beds: _____ number of present roommate: _____

Hygiene prevention measures at entrance of the room: ▫ Yes ▫ No

Modification of preventive measures during hospitalization ▫ Yes ▫ No

If Yes, please specify _____

Does the patient wear a-mask when outside of the room for clinical examination or any other reasons?

▫ Never ▫ Sometimes ▫ Always

Date admitted to the ward: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Date discharged from the ward: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Section 6: Biological parameters

Parameter	Value	Parameter	Value
White blood cell count, G/L		Neutrophil count, G/L	
Lymphocyte count, G/L		Monocyte count, G/L	
Platelet count, G/L		Red blood cells count T/L	
Haemoglobin, g/L		Prothrombin %	
Creatinine, µmol/L		Urea mmol/L	
AST U/L		ALT U/L	
LDH U/L		CRP mg/L	
Sodium (Na+) mmol/L		Potassium (K+) mmol/L	

Sections 1-4 are adapted from the interim case reporting form for 2019 Novel Coronavirus (2019-nCoV) of WHO (World Health Organization)

https://www.who.int/docs/default-source/coronaviruse/20200121-2019-ncov-reporting-form.pdf?sfvrsn=96eff954_4

***Sections 5 is added to the WHO CRF to explore more in details the nosocomial risk**

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Health Care Professional (HCP) Case Report Form

NOSO-COR project

If the HCP is hospitalized, please complete also a patient CRF for this HCP

Section 1: Hospital administrative information

Date of inclusion: _ / _ / ___ HCP Identification code: [_ _][_ _] [_ _][_ _] [_ _][_ _][_ _][_ _][_][_ _]

Hospital name: Country :

Region: Zip code:

Section 2: Socio-demographic characteristics of HCP

Case classification: Confirmed ☐ Probable ☐

Date of positive sampling: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Date of birth: [_M_][_M_]/[_Y_][_Y_][_Y_][_Y_] Gender: Male ☐ Female ☐

Weight (Kg) [__][__] Height (cm) [__][__][__][__]

Occupation: ☐ Nurse ☐ Nurse-assistant ☐ Medical doctor ☐ Biologist ☐ Laboratory technician ☐ Others: _____

Specificity of the working ward ☐ ICU ☐ Surgery ☐ Medicine ☐ Obstetrics ☐ Other: _____

Do you work in several wards: Yes ☐ No ☐

If Yes, please specify _____

Section 3 : Clinical information

Date of first symptoms: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_] Do not know ☐

Date of end symptoms: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_] Do not know ☐

Health status at inclusion: Not recovered ☐ Recovered ☐

If the HCP is hospitalized, please complete also a patient CRF for this HCP

Symptoms at suspicion: (Please tick all reported symptoms)

☐ Fever/chills ☐ Sore throat ☐ Diarrhoeas ☐ Irritability/confusion

☐ General weakness ☐ Runny nose ☐ Nauseas/vomiting ☐ Pain *(tick all that apply)*

☐ Cough ☐ Shortness of breath ☐ Headache ( ) Muscular ( ) Chest

☐ Anosmia ☐ Ageusia ( ) Abdominal ( ) Joints

☐ Others: _____

Clinical signs:

Temperature at suspicion: [__][__][__] ▫ °C / ▫ F Unknown ▫

Check all observed signs:

▫ Pharyngeal exudate ▫ Coma Lung X-ray: ▫ Yes ▫ No

▫ Conjunctival injection ▫ Dyspnoea / tachypnoea If Yes: ▫ Abnormal lung X-ray finding

▫ Seizure ▫ Abnormal lung auscultation

▫ Other, specify: _____

Health Care Professional (HCP) – Case Report Form- NOSO-COR project – Version 3_2020.03.19

Underlying conditions and comorbidity at admission: (Please tick all reported)

- ▫ Pregnancy (trimester: _____)
- ▫ Cardiovascular disease
- ▫ Hypertension
- ▫ Diabetes
- ▫ Liver disease
- ▫ Post-partum (< 6 weeks)
- ▫ Immunodeficiency, including HIV
- ▫ Heart failure
- ▫ Renal disease
- ▫ Chronic lung disease
  - ▫ Asthma
  - ▫ COPD
  - ▫ Emphysema
  - ▫ Chronic bronchitis
- ▫ Chronic neurological or neuromuscular disease
- ▫ Malignancy
- ▫ Hypothyroidism
- ▫ Rheumatic disease
- ▫ Other, specify: _____

Smoking status
- ▫ Current smoker
- ▫ Ex-smoker, If Yes, quit date [_Y_][_Y_][_Y_][_Y_]
- ▫ Never

Alcohol consumption: ▫ Daily ▫ Weekly ▫ Occasionally ▫ Never

Section 4: Sources of exposure for suspected or confirmed SARS-Cov-2 infected HCP

Information on the unit where nosocomial transmission might have been occurred:

Number of patients in the unit: _____

Number of beds in the unit: _____

Number of probable or confirmed 2019-nCoV patients in contact with the HCP: _____

Number of beds per room of the infected patient ☐ 1 ☐ 2 ☐ Others : ___

Information on the hospitalization room of SARS-Cov-2 infected patients:

Closed room: Yes ☐ No ☐

Room identified with a warning sticker: Yes ☐ No ☐

If yes (Multiple choice):

☐ Caution « droplets » ☐ « Caution« contact » ☐ « Caution « air » ☐ « Contact complementary caution »

Air conditioner: Yes ☐ No ☐

Other aeration: Yes ☐ No ☐

If Yes, please detail: _____

Room with airlock: Yes ☐ No ☐

Bio-cleaning: Yes ☐ No ☐

☐ Detergent-disinfectant only ☐Bleach alone 0,5% ☐ Detergent-disinfectant + bleach 0,5% ☐Others_____

If Yes, frequency: ☐ Once a day ☐Every 2 days ☐ Once a week ☐Others_____

Availability of personal protective equipment *in the ward:*

Mask fit-tested NIOSH-certified disposable N95: Yes ☐ No ☐ NA ☐

Surgical mask: Yes ☐ No ☐ NA ☐

Single use Long sleeve over-blouse:	Yes ☐	No ☐	NA ☐
Protective apron:	Yes ☐	No ☐	NA ☐
Vinyl gloves (single utilisation)	Yes ☐	No ☐	NA ☐
Single use nitrile gloves:	Yes ☐	No ☐	NA ☐
Protective glasses:	Yes ☐	No ☐	NA ☐

Availability of hand rub hydroalcoholic solution *in the unit:*

Available in the unit: Yes ☐ No ☐

If available: ☐ Individual format ☐ in unit's room ☐ in common parts of the unit

Section 5: Laboratory information

Nasopharyngeal sample taken: Yes ☐ No ☐ If yes, date: _ _ / _ _ / _ _ _ Time (1 to 12):
▫ AM (before noon)
▫ PM (after noon)

Name of confirming laboratory: _____

Date of laboratory confirmation: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_] Time (1 to 12):
▫ AM (before noon)
▫ PM (after noon)

Please specify which assay was used: _____

Result: SARS-CoV-2 positive ☐ SARS-CoV-2 negative ☐ Other respiratory virus tested: Yes ☐ No ☐

If Yes, Influenza A (no sub-type) ☐ Influenza A(H1N1) $_{pdm09}$ ☐ Influenza A(H3N2) ☐ Influenza B (no sub-type) ☐ Influenza B/Yamagata ☐ Influenza B/Victoria ☐ RSV ☐ Other virus (_____) ☐ No virus ☐

Sequencing will be done? Yes ☐ No ☐ Unknown ☐

Hospital characteristics and infection control policies - NOSO-COR project

Section 1: Administrative data

Name of the hospital: _____ Country : _____

Name of the city: _____ University-affiliated hospital: Yes ☐ No ☐

Number of admissions per year (2018): _____ Number of hospitalizations per year (2018):

Section 2: Hospital capacities at the time of the survey

Number (Nb) of adult beds		Nb of pediatric beds:	
Nb in medicine units:		Nb in medicine units:	
Nb in surgery:		Nb in surgery:	
Nb in obstetrics:		Nb in neonatology:	
Nb in intensive care units		Nb in intensive care units	
Other units:		Other units:	

Section 3: Health Care Professionals (HCP)

Nb of nurses: _____

Nb of assistant-nurses: _____

Nb of permanent medical doctors: _____

Nb of lab staff: _____

Nb of administrative staff: _____

Others (pharmacists, physio, etc.) _____

Section 3: SARS-Cov-2 local alert

Presence of at least one infection control unit in the hospital: Yes ☐ No ☐

Presence of a validated protocol exist regarding infection control in the hospital: Yes ☐ No ☐

Date of the protocol validation: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Local guidelines regarding SARS-Cov-2: Airborne precautions ☐ Contact precautions ☐ Droplets precautions ☐

For the infected patient:

– Surgical mask if moving:	Yes ☐	No ☐	Not applicable ☐
– Isolation	Yes ☐	No ☐	Not applicable ☐
– Mandatory room door closed:	Yes ☐	No ☐	Not applicable ☐
– Air conditioning room stopped:	Yes ☐	No ☐	Not applicable ☐
– Hand disinfection before moving outside the room:	Yes ☐	No ☐	Not applicable ☐
– Cohorting (HCP dedicated for the patient):	Yes ☐	No ☐	Not applicable ☐
Visits restriction:	Yes ☐	No ☐	Not applicable ☐

For non-infected patients from the same unit as the case:

– Identification of contact patients:	Yes ☐	No ☐	Not applicable ☐
– Cohorting (HCP dedicated for the contacts):	Yes ☐	No ☐	Not applicable ☐

– **Other preventive measures:** _____

For HCP providing care for the infected patient before entrance in the room

– Mask :fit-tested NIOSH-certified disposable N95 filtering facepiece respirator before entrance in the patient room: Yes ☐ No ☐ Not applicable ☐

– Hand disinfection :	Yes ☐	No ☐	Not applicable ☐
– Use non sterile gloves	Yes ☐	No ☐	Not applicable ☐
– Wearing gowns :	Yes ☐	No ☐	Not applicable ☐
– Eye protection :	Yes ☐	No ☐	Not applicable ☐
- Dedicated medical equipment:	Yes ☐	No ☐	Not applicable ☐

- Adapted environmental cleaning and disinfection procedures Yes ☐ No ☐ Not applicable ☐
- Others specific measures : _____

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