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PASS Study Monthly Clinic Visit Questions

SUBJECT ID#: P126-S00						Visit Date: / _	/ Visit #:
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1. Since your last clinic visit, have you received a COVID-19 vaccination?

□*Yes	ΠNο	, If *Yes, please fill out a COVID-19 vaccination history form.

2. Since your last clinic visit, have you received any other vaccinations?

□*Yes	ΠNo
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If *Yes, please specify:

Vaccine Name	Vaccine Indication

3. Since your last clinic visit, have you enrolled in any other COVID-19 trial(s)?

 \square^* Yes \square No \square^* No, but plan to enroll soon (i.e. in the next one or two months)

If ***Yes** or ***No, but plan to enroll soon**, does it involve experimental vaccination or medication for COVID-19?

□*Yes □No

If *Yes, the participant may no longer be eligible to participate in the PASS study. Please review the current protocol eligibility criteria.

4. (A) If you are being seen monthly in clinic:

Have you been filling out your symptoms questionnaires at least twice a month and your risk exposure/PPE/social distancing questionnaires once a month?

Yes	ΠNα	, 🗆	Not	ар	plicable

(B) If you are being seen every three to six months in clinic:

Have you been filling out your risk exposure/PPE/social distancing questionnaires once every three to six months?

Yes No Not applicable

IDCRP-126, USUHS-C/NMRC v3.0, 28 December 2020

CRF ENTRY	CRF QC	DB ENTRY	DB QC
Initial/date	Initial/date	Initial/date	Initial/date

PASS Study Mon	thly Clinic Vis	it Question	IS
SUBJECT ID#: P126-S00-	Visit Date:	//	Visit #:
5. Have you been tested for COVID-19	since your last cl	linic visit?	
□*Yes □No			
If *Yes, number of tests done: 1	2 🛛 3 🗖 4 🚺] 5	
	#1 (complete for		
Date of Test//	(dd/N		
Reason for Testing Symptoms			
COVID-19 expo	osure	Pre-proce	dure (medical)
□Screening test		Other	
Location of Testing WRNMMC CO	VID-19 outpatient	testing facility	
	ergency departme	nt	
Self-collected to	est		
Other outpatier	nt facility (name of	site)	
Other inpatient	facility (name of s	ite)	
Type of Test DPCR DAntig			
COVID-19 Test Res			mptoms?
Negative *Positi	ve 🗸 🛛 Y	es 🗆 No	
If the COVID-19 test was positive an			
How many days did your syr Please ente			1S)? ays:
Did you fill out a symptom questionna			
	evere symptoms?		
Were you seen in an emergency	ease fill out a pap	ber questionna	aire in clinic today.
department for COVID-19?			
	If *Yes		
	Name of site:		
	Date of visit:	/	/
		(dd/MMM/yyyy)	
Were you hospitalized for COVID-19?	lf * Yes Name of		
□*Yes □No	hospital:		
If *Yes, what was the hospitalization	Date of hospital		
discharge diagnosis:	admission:	/	_/
		(dd/MMM/yyyy)	
	Date of hospital		/
	discharge:	(dd/MMM/yyyy)	
ENTRIES FOR ADDITIONAL TESTS AF	RE FOUND AT TH	E END OF THI	S FORM

IDCRP-126, USUHS-C/NMRC v3.0, 28 December 2020

CRF ENTRY	CRF QC	DB ENTRY	DB QC
Initial/date	Initial/date	Initial/date	Initial/date

PASS Study Monthly Clinic Visit Questions

SUBJECT ID#: P126-S00-			Visit Date: /	/Visit #:

6. Have you started any new medications since your last clinic visit?

□*Yes □No

If *Yes, what are the names and indications of the medications?

Medication Name	Medication Indication
1.	
2.	
3.	
4.	
5.	

7. Have you had any changes to your medical health since your last clinic visit?

□*Yes □No

If *Yes, please describe the changes:

8. Other than you, how many people lived in your household this past month?

Number of people: _____

9. Other than you, how many people in your household have been vaccinated against COVID-19?

Number of people: _____

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CRF ENTRY	CRF QC	DB ENTRY	DB QC
Initial/date	Initial/date	Initial/date	Initial/date

PASS Study Monthly Clinic Visit Questions					
SUBJECT ID#: P126-S00-	Visit Date: / / Visit #:				
10. Not including you, have any of your ho COVID-19 since your last clinic visit?	ousehold members been diagnosed with				
□*Yes □No					
If * Yes , please tell us the number of ir	ndividuals who tested positive (other than you):				
\Box_1 \Box_2 \Box_3 \Box_4 \Box_5 [more than 5				
11. Saliva obtained today?					
□Yes □*No					
If *No, please specify reason:					
Date Obtained:	_ Time Obtained:				
CRC Initials	_				
12. Blood obtained today?					
□Yes □*No					
If * No , please specify reason:					
Number of tubes obtained:					
	– _ Time Obtained:				
CRC Initials					

CRF ENTRY	CRF QC	DB ENTRY	DB QC
Initial/date	Initial/date	Initial/date	Initial/date

PASS Study Monthly Clinic Visit Questions						
SUBJECT ID#: P126-S	500-	Visit Date:	/ / Visit #:	_		
	COVID-19 TEST	#2 (complete for	each test)			
Date of Test	//	/ (dd/M	MM/yyyy)			
Reason for Testing			Travel			
	COVID-19 exp	osure	Pre-procedure (medical)			
	Screening test	t	□Other			
Location of Testing		VID-19 outpatient t	esting facility			
	—	ergency departmen	• •			
	Self-collected	test				
	Other outpatie	nt facility (name of s	site)			
	_		te)			
Type of Test		igen Do not kr	,			
	COVID-19 Test Result $/= 2$ Did you have any symptoms?					
	egative D * Posit		es 🗖 No			
			oms, complete the next fields.			
How man		mptoms last (durati er a number betwee				
Did you fill out a sy	ymptom questionn	aire reflecting your	$\square \nabla \alpha \alpha$ $\square * N \alpha$	-		
	most	severe symptoms?				
Woro you soon	If *No, p	lease fill out a pap	er questionnaire in clinic today	′ .		
departme	in an emergency nt for COVID-19?	∐*Yes ∐No				
•		If *Yes				
		Name of site:				
		Date of visit:	//			
Were you hospitalized	for COVID-19?	If *Yes				
□*Yes □No		Name of hospital:				
If * Yes , what was the I	nospitalization					
discharge diagnosis: Date of hospital admission:/						
			(dd/MMM/yyyy)			
		Date of hospital	/ /			
		discharge:	/ / (dd/MMM/yyyy)			
ENTRIES FOR ADDIT	TIONAL TESTS A	RE FOUND AT THI	E END OF THIS FORM			

CRF ENTRY	CRF QC	DB ENTRY	DB QC
Initial/date	Initial/date	Initial/date	Initial/date

PASS Study	Monthly Clinic Vis	it Questions				
SUBJECT ID#: P126-S00-	Visit Date:	/ / Visit #:				
COVID-19	TEST #3 (complete for	each test)				
	/ (dd/M	ММ/уууу)				
Reason for Testing Symptom	IS	Travel				
	9 exposure	Pre-procedure (medical)				
Screenin	g test	Other				
Location of Testing	C COVID-19 outpatient t	esting facility				
	C emergency departmer	nt				
☐Self-colle	cted test					
☐Other ou	Other outpatient facility (name of site)					
☐Other inp	atient facility (name of si	te)				
Type of Test DPCR	Antigen Do not kr	Now				
COVID-19 Test Result / Did you have any symptoms?						
□Negative □*		es 🗆 No				
If the COVID-19 test was posit	ive and you had sympt e our symptoms last (durat					
Please	e enter a number betwee	n 1 and 100 days:				
Did you fill out a symptom ques	tionnaire reflecting your	□Yes □*No				
	nost severe symptoms? No please fill out a par	er questionnaire in clinic today.				
Were you seen in an emerg	$ency \square *_{Ves} \square No$					
department for COVID	-19?					
	If * Yes Name of site:					
	Date of visit:	/ / /				
Were you hospitalized for COVID-1	9? If * Yes	(dd/MMM/yyyy)				
	Name of					
	hospital:					
If *Yes, what was the hospitalization discharge diagnosis: Date of hospital						
admission:/ / /						
	Date of hospital					
	discharge:					
ENTRIES FOR ADDITIONAL TES	TS ARE FOUND AT TH	(dd/MMM/yyyy) E END OF THIS FORM				

CRF ENTRY	CRF QC	DB ENTRY	DB QC
Initial/date	Initial/date	Initial/date	Initial/date

PASS Study Monthly Clinic Visit Questions					
SUBJECT ID#: P126-S	500-	Visit Date: /	//	Visit #:	
	COVID-19 TEST	#4 (complete for e	each test)		
Date of Test		(dd/M			
Reason for Testing			Travel		
	COVID-19 exposure Pre-procedure (medical)				
	Screening test			(,	
Location of Testing		VID-19 outpatient to			
	—	ergency departmen			
	Self-collected t	• • •	l.		
	_				
	_	nt facility (name of s	-		
		facility (name of sit	-		
	OVID-19 Test Res			nptoms?	
NLL If the COVID-19 te	egative *Positi			the next fields	
	y days did your sy				
	Please ente	r a number betwee	n 1 and 100 da	vs:	
Did you fill out a s	ymptom questionna	aire reflecting your		No	
		evere symptoms?	er questionna	ire in clinic today.	
Were you seer	n in an emergency			ine in chine today.	
	ent for COVID-19?				
		If * Yes Name of site:			
		Name of Site.		·	
		Date of visit:	/	/	
			(dd/MMM/yyyy)	/	
Were you hospitalized	for COVID-19?	If * Yes Name of			
□*Yes □No		hospital:			
If *Yes, what was the hospitalization					
discharge diagnosis: Date of hospital admission:/					
			(dd/MMM/yyyy)		
		Date of hospital	/	/	
		discharge:	/ (dd/MMM/yyyy)	/	

ENTRIES FOR ADDITIONAL TESTS ARE FOUND AT THE END OF THIS FORM

CRF ENTRY	CRF QC	DB ENTRY	DB QC
Initial/date	Initial/date	Initial/date	Initial/date

PASS S	tudy Monthl	y Clinic Vis	it Questions			
SUBJECT ID#: P126-S00-		/isit Date:	/ / Visit #:			
COVID-19 TEST #5 (complete for each test)						
	.//	(dd/M	ММ/уууу)			
Reason for Testing $\Box S_{3}$	/mptoms		Travel			
	OVID-19 exposu	re	Pre-procedure (medical)			
	creening test		Other			
Location of Testing \Box_W	RNMMC COVID	-19 outpatient t	esting facility			
Πw	RNMMC emerge	ency departmen	ıt			
□se	elf-collected test					
	Other outpatient facility (name of site)					
	ther inpatient fac	ility (name of si	te)			
Type of Test	CR 🛛 Antigen	🛛 Do not kr	now			
COVID-19 Test Result Did you have any symptoms?						
•	e □ *Positive		es 🗆 No			
			oms, complete the next fields.			
	Please enter a	number betwee	n 1 and 100 days:			
Did you fill out a sympto	m questionnaire	reflecting your	□Yes □*No			
		re symptoms?	er questionnaire in clinic toda	V.		
Were you seen in an department for	emergency	I*Yes □No		· · ·		
		If *Yes				
		Name of site:				
		Date of visit:	/ / /			
Were you hospitalized for CO	OVID-19?	If *Yes	(dd/MMM/yyyy)			
□*Yes □No						
		hospital:				
If *Yes, what was the hospitalization discharge diagnosis: Date of hospital						
		admission:	(dd/MMM/yyyy)			
	D	ate of hospital	/ /			
		discharge:	/ / / (dd/MMM/yyyy)			
ENTRIES FOR ADDITIONA	L TESTS ARE H	OUND AT THE	E END OF THIS FORM			

CRF ENTRY	CRF QC	DB ENTRY	DB QC
Initial/date	Initial/date	Initial/date	Initial/date