INSTRUCTIONS FOR COLLABORATIVE COHORT OF COHORTS FOR COVID-19 RESEARCH (C4R) COVID Tracking Form CVT, VERSION 1.0 QUESTION BY QUESTION INSTRUCTIONS (QxQ)

I. GENERAL INSTRUCTIONS

The COVID Tracking Form is to be completed for all eligible COVID C4R cases.

Header Information: The header information consists of key fields which uniquely identify each recorded instance of a form.

0a. Admission/Death date: Enter the date the participant was admitted into the hospital or the date of death for out-of-hospital deaths found on the death certificate.

0b. Staff Code: Record the SPIROMICS staff code of the person who collected the data. This code is assigned to each person at each site by the GIC. If you do not have a staff code and are collecting SPIROMICS data, please contact the GIC in order to receive your own individual staff code.

II. DETAILED INSTRUCTIONS FOR EACH ITEM

Please answer every question on this form.

Item 1. Date: Enter the date this form is being updated. This field can be updated every time you have an update on the event. The last date update should be when the case is sent to the CSCC.

Item 2. Notes: The use of this field is for specific updates. Date of record requests, confirming that an event is not eligible, notations of missing items from the case materials can all be described in the notes field.

Item 3. Type of Event: Select only one option among the three possible choices.

- Select in-hospital death if participant died during a hospital admission.
- Select out-of-hospital death if participant died outside of a hospital admission.
- Select non-fatal hospitalization if participant was hospitalized and was discharged.

Item 4. How did the center find out about the event (Select all that apply): Select all of the choices from the options that apply.

- C4R COVID Questionnaire
- Other cohort follow-up (including events surveillance)
- Participant or proxy contacted the field/clinical center
- Cohort field/clinical center visit
- During investigation of another event
- Obituary or local news
- Electronic medical record surveillance or health information exchange
- NDI or local vital statistics search
- Other: _____

Item 5. Status Result Code: This field should be updated with each case update.

- Pending records request is when the event is new and a CVT form has just been created.
- Event Record requested is when an event has been requested from the hospital, but not received by the field center yet.
- Confirmed, no event to investigate is if the case does not qualify for C4R review.
- Confirmed, records not available is if records cannot be obtained for an event.
- Medical records received for event is if the medical records have been received but are being blinded and not yet sent to the GIC.
- Records sent to GIC; event is complete is if the record is finalized, blinded, and being sent to the GIC. This is the final step for a record.
- Patient declined medical release is if the patient has declined to release access to their medical records.

Item 6. Are the following included in the packet?: Use the checkboxes for each question below to indicate the materials in the packet.

Item 6a. Discharge Diagnosis and ICD Codes: Mark the checkbox if the discharge diagnosis or ICD codes are included in the packet.

Item 6b. ICD Code Sheet: Mark the checkbox if the ICD Code Sheet is included in the packet.

Item 6c. Admission note, History and Physical (H&P), HPI: Mark the checkbox if the admission note, History and Physical (H&P) or HIP are included in the packet.

Item 6d. ED Note: Mark the checkbox if ED Note is included in the packet.

Item 6e. Physician consult notes (all services): Mark the checkbox if Physician consult notes (including all services) are included in the packet.

Item 6f. ICU admission note (if applicable): Mark the checkbox if ICU admission note is included in the packet.

Item 6g. Discharge note/summary: Mark the checkbox if discharge note or summary are included in the packet.

Item 6h. Death Certificate (if applicable) : Mark the checkbox if the death certificate is included in the packet.

Item 6i. Radiology reports: Mark the checkbox if the radiology reports are included in the packet. Radiology reports can include any of the following: chest radiography (x-ray), chest computed tomography (CT), echocardiogram (TTE, TEE), head computed tomography (CT), brain magnetic resonance imaging (MRI) or lower extremity ultrasound (doppler/duplex).

Item 6j. Laboratory reports: Mark the checkbox if the laboratory reports are included in the packet. Laboratory reports can include any of the following: PCR, antigen testing, serology, creatinine, troponin, or arterial blood gas (ABG).

Item 6k. Medications: Mark the checkbox if the medications are included in the packet. Medications can include home medication list (e.g. ACE inhibitors, anticoagulants) or hospitalization medications.

Item 6l. Vital Signs: Mark the checkbox if the vital signs are included in the packet. Vital signs can include respiratory rate, O2 saturation, or O2 supplementation.

Item 6m. Electrocardiogram report (if suspected MI or new atrial fibrillation): Mark the checkbox if the electrocardiogram report is included in the packet.

Save and close the form.