

Global COVID-19 Clinical Platform

Case Report Form (CRF) for Post COVID conditions (Post COVID-19 CRF¹)

The WHO has established a Global Clinical Data Platform¹ of COVID-19 and invites all Member States and health facilities to report anonymised patient-level clinical information to the WHO platform using standardized Case Report Form (CRF):

- *Core CRF* captures clinical information of individuals hospitalized for COVID-19
- *Core-P CRF* has information of pregnant women hospitalized for COVID-19
- *MIS-CRF* has information related to multisystemic inflammatory syndrome in children and adolescents temporally related to COVID-19
- *Post COVID-19 CRF*, designed to build upon the Core CRF and assess the medium- and long-term sequelae of COVID-19

The Post COVID-19 CRF includes 3 modules:

Module 1 includes background demographic and clinical information of the acute episode of COVID-19.

Module 2 includes questions to help identifying patients who require further clinical evaluation.

Module 3 includes medical assessment and results of examinations, tests, or diagnosis made during the follow up visit. Based on results, patients should be referred for clinical care, or rehabilitation as per national protocols.

The Post COVID-19 CRF is intended to serve as: (i) A clinical tool that can be used by Member States to document the mid- and long-term sequelae of COVID-19. Uniformity in the follow up of patients could ensure that mid- and long-term clinical and rehabilitation needs are identified, and patients are provided the care they need; (ii) WHO is not necessarily recommending the comprehensive testing described in the CRF for all individuals; clinician judgement is required to select the test needed for clinical care. This CRF is a tool for gathering standardized information regarding the post COVID-19 condition through the WHO Clinical Data Platform. Such data collation and its analysis would improve national and global knowledge of the consequences of COVID-19, inform further public health responses and prepare for large investigational studies.

Criteria for completion of Post COVID-19 CRF: Variables' dictionary available on WHO website¹ support data entry. The CRF can be administered either as part of routine follow up or at a specific time point to any patient in the post-acute phase of COVID-19, regardless of hospitalization. While it is suggested to prioritize the completion of the CRF for patients *who were hospitalized for a severe or critical* episode of COVID-19, the CRF should be administered, where possible, also to patients who suffered from COVID-19, including those with mild or moderate illness, and who *received care either at home or in a hospital setting*.

Time-points for administration: The form can be completed any time during follow up after an acute episode of COVID-19. However, to support standardization and data comparability, it should preferably be completed 4 to 8 weeks and 6 months after hospital discharge from the acute ward or after acute illness for individuals who have not been hospitalized. In case of persistent symptoms/signs after hospital discharge or after acute illness, it is recommended to complete the CRF at 3-month intervals, for as long as needed, or at 6 months interval, if no symptoms persist (see figure below).

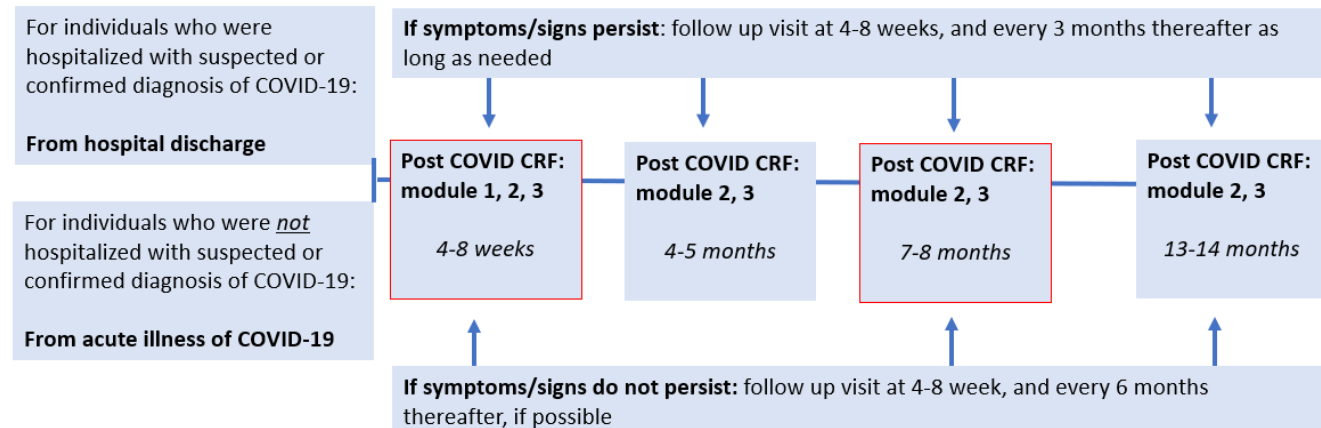
Mode of administration:

Module 1-2: face-to-face administration and completion by a health care worker is preferred. However, when this is not possible, the form can be either self-administered, or completed remotely (online or through telephone) by the caregiver. For children, the form should be completed by the primary caregiver (preferred) or by the legal guardian.

Module 3: face-to-face administration and completion by a health care worker.

Module 1 needs to be completed only once during the first follow up visit, while Modules 2 and 3 should be completed at every follow up visit.

General guidance: Please contact COVID_ClinPlatform@who.int if you need assistance with data entry, if you have any query on the CRF, and to let us know that you are using the forms.



¹ <https://www.who.int/teams/health-care-readiness-clinical-unit/covid-19/data-platform>

Date of onset of symptoms of **acute** COVID-19: [D][D]/[M][M]/[Y][Y][Y][Y];
 Did the participant receive a **diagnosis** of COVID-19 by a health care worker during the **acute illness**?

Yes No Unknown;

Did the participant have a **diagnostic test**? Yes No Unknown;

If yes, complete the 3 questions below:

Did the participant have a **PCR test** during the acute illness?

Yes, positive Yes, negative Not performed Unknown;

If positive, date of positive PCR test: [D][D]/[M][M]/[Y][Y][Y][Y]

Did the participant have an **antigen test** (rapid test) during acute illness?

Yes, positive Yes, negative Not performed Unknown;

If positive, date of positive antigen test: [D][D]/[M][M]/[Y][Y][Y][Y]

Did the participant have an **antibody test** during/after the acute illness?

Yes, positive Yes, negative Not performed Unknown;

If positive, date of positive antibody test: [D][D]/[M][M]/[Y][Y][Y][Y]

Please grade the **severity of acute illness** of COVID-19 based on WHO criteria described in the table below.

Please tick the classification that applies: Mild Moderate Severe Critical Unknown

WHO Clinical Classification	Based on available clinical records	Based on self-report, if clinical records are not available
Mild	No hypoxia or pneumonia	Did not receive oxygen
Moderate	Clinical signs of non-severe pneumonia <i>AND</i> SpO ₂ ≥ 90% on room air	
Severe	Adults/adolescents: Clinical signs of severe pneumonia <i>AND</i> SpO ₂ < 90% on room air; <i>OR</i> RR > 30 breaths/min Children: Clinical signs of severe pneumonia <i>AND at least one of the following:</i> central cyanosis; <i>OR</i> SpO ₂ < 90%; <i>OR</i> severe respiratory distress (e.g. fast breathing, grunting, very severe chest indrawing); <i>OR</i> general danger sign(s) (inability to breastfeed or drink, lethargy or unconsciousness, convulsions)	Received oxygen (or told you they needed it, but it was not available)
Critical	ARDS; <i>OR</i> sepsis/septic shock; <i>OR</i> pulmonary embolism, acute coronary syndrome, acute stroke; <i>OR</i> Multi-Inflammatory Syndrome in Children and adolescents temporally related to COVID-19	Received invasive ventilation (or max available respiratory support)

Highest level of care received during the acute episode? Admitted to the hospital Self-care/Over-the-counter Treated at home/Telemedicine Outpatient Unknown;

If admitted to the hospital:

Date of hospital admission: [D][D]/[M][M]/[Y][Y][Y][Y];

Date of hospital discharge: [D][D]/[M][M]/[Y][Y][Y][Y];

Duration of hospital stay (total) during acute episode of COVID-19: |__| |__| |__| days;

Was the participant admitted to Intensive Care Unit or lower dependency unit? Yes No Unknown;

Did the participant receive oxygen therapy during the acute illness? Yes No Unknown

If yes, did the participant receive invasive ventilation (a machine that breaths for you)? Yes No Unknown

If yes, did the participant receive non-invasive ventilation (e.g. mask providing pressurized air and oxygen to help you breathing)? Yes No Unknown;

Treatment: Did the participant receive **treatment for COVID-19?** Yes No;

If yes, complete section below:

Antibiotic received? Yes No Unknown;

If yes, specify: Macrolides (e.g. Azithromycin, clarithromycin) Fluoroquinolones (e.g. ciprofloxacin, levofloxacin) 3rd and 4rd generation Cephalosporins (e.g. ceftriaxone, cefotaxime, ceftazidime, cefepime)

Carbapenems (e.g. imipenem, meropenem) Piperacillin + Tazobactam Amoxicillin-clavulanate

Cotrimoxazole Other antibiotics _____;

Duration of antibiotics therapy (days): [][]

Antithrombotic/anticoagulation drugs received? Yes No Unknown;

If yes specify: Unfractionated heparin Low molecular weight heparin Warfarin Direct oral anticoagulant

Other _____; Dose: Preventive dose Therapeutic dose

Antiviral drugs received? Yes No Unknown;

If yes, specify: Lopinavir/Ritonavir Darunavir +/- cobicistat Remdesivir Favipiravir Acyclovir/Ganciclovir

Oseltamivir Other _____;



1.5 Clinical management while unwell during the acute COVID-19 episode continuation

Blood-derived products received? Yes No Unknown;

If yes, specify: IV immune globulin Convalescent plasma Other _____;

Chloroquine/hydroxychloroquine received? Yes No Unknown;

If Yes, purpose: malaria prophylaxis COVID-19 prophylaxis; COVID-19 treatment

Experimental agents:

Ivermectin received? Yes No Unknown

Interferon received? Yes No Unknown

Eculizumab received? Yes No Unknown

Pytotherapy received? Yes No Unknown

IL-1 Antagonists received? Yes No Unknown;

If Yes, specify: Anakinra Canakinumab; Other IL-1 antagonist;

IL-6 Antagonists received? Yes No Unknown;

If Yes, specify: Siltuximab Sarilumab Tocilizumab Other IL-6 antagonist;

Kinase Inhibitors received? Yes No Unknown;

If Yes, specify: Acalabrutinib Ibrutinib Zanubrutinib Baricitinib Ruxolitinib Tofacitinib

Ruxolitinib; Other Kinase inhibitors;

Neutralizing monoclonal antibodies received? Yes No Unknown; If Yes, specify: _____;

Other agents: Yes No Unknown; If Yes, specify: _____;

Steroids received? Yes No Unknown;

If yes specify: Dexamethasone Hydrocortisone Prednisone Methylprednisolone Other _____

Duration of steroid therapy (days): [][] Dose: _____ Route: Oral Intravenous Inhaled

PARTICIPANT ID² | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ |

Module 2. Follow up interview

 This module is completed by patient caregiver (in case of children) health care worker

Date of follow up interview: [_] [_] [_] / [_] [_] [_] / [_] [_] [_] [_]

Country _____ City: _____ Facility name (if applies) _____

2.1 Hospital admission after the acute illness of COVID-19

 Was the participant **admitted to the hospital** for a possible **complication** of COVID-19 **after the acute illness?**
 Yes No Unknown; If yes, date of (re)admission [_] [_] [_] / [_] [_] [_] / [_] [_] [_] [_] and please specify type of complication in section 3.5

2.2 Reinfection

 Did the participant experience a second episode/reinfection with SARS-CoV-2? Yes No Unknown

 If yes, date of **second positive PCR:** [_] [_] [_] / [_] [_] [_] / [_] [_] [_] [_]

 What is the highest level of care received during the second episode? Admitted to the hospital Self-care/Over-the-counter Outpatient/Telemedicine Community facility Unknown

2.3 Vaccination status for Covid-19

 Did the patient receive a Covid-19 vaccine? Yes No Unknown

 If yes, number of doses received: 1 2 Unknown

Product name of COVID-19 vaccine dose 1:

 Moderna Pfizer-BioNTech AstraZeneca Janssen Novavax Other Unknown;

Date of vaccine dose 1: [_] [_] [_] / [_] [_] [_] / [_] [_] [_] [_]

Product name of COVID-19 vaccine dose 2:

 Moderna Pfizer-BioNTech AstraZeneca Janssen Novavax Other Unknown;

Date of vaccine dose 2: [_] [_] [_] / [_] [_] [_] / [_] [_] [_] [_]

 Source of information: Documented Evidence (Vaccine card/Vaccine Passport/Facility based record/other); Recall

2.4 Occupational status

Is there a change in the duration (hours) of working or schooling as compared to before acute illness of COVID-19?

 Yes No Unknown;

If yes, specify: Working/schooling time increased Working/schooling time decreased Stopped working or schooling since COVID-19 Unknown;

If less or not working or schooling, what is the reason? Poor health New caring responsibility Work or school less or not available due to COVID-19 restrictions Other Prefer not to say Unknown

If other scales were used: Name of the scale: _____ Score [_] [_] / [_] [_]

² **Participant ID:** obtain the 4-digit **site code** by contacting COVID_ClinPlatform@who.int. Enter a 5-digit **patient number** (e.g. 00001, 00002, etc) and record the information in a logbook

2.6 Incidence of symptoms after acute illness of COVID-19

2.5 Functioning (do not need complete this section for children <15yrs)				
Ability to self-care: <input type="checkbox"/> Same as before COVID-19 <input type="checkbox"/> Worse <input type="checkbox"/> Better <input type="checkbox"/> Unknown				
Think back over the past 7 days. How much difficulty has the participant had with the following:	Score: 0 No Difficulty 1 Mild Difficulty 2 Moderate Difficulty 3 Severe Difficulty 4 Extreme Difficulty or Cannot do	Compared to before COVID-19, are you better/worse/same?		
		Better	Worse	Same
Standing for long periods such as 30 minutes?				
Taking care of your household responsibilities?				
Learning a new task, e.g. learning how to get to a new place?				
Joining in community activities (e.g. festivities, religious, other)?				
Being emotionally affected by your health problems?				
Concentrating on doing something for ten minutes?				
Walking a long distance such as a kilometre (or equivalent)?				
Washing your whole body?				
Getting dressed?				
Dealing with people you do not know?				
Maintaining a friendship?				
Your day-to-day work/school?				
TOTAL score				

Did the participant experience any of the following symptoms after the acute illness of COVID-19/ since hospital discharge for COVID-19, that were **not experienced** before the acute episode of COVID-19? Yes No Unknown;
If yes, please respond to questions below:
Anxiety: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Behaviour change: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Can't move and/or feel one side of body or face: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Chest pain: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Constipation: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;

Depressed mood: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Diarrhoea: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Dysmenorrhea Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Dizziness/light headedness: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Fainting/blackouts: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Fever: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Forgetfulness: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Jerking of limbs: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Joint pain/swelling: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Loss of appetite: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Loss of interest/pleasure: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Lumpy lesions: (purple/pink/bluish) on toes/COVID toes: Yes, but not present anymore Yes, still present
Yes, intermittent No Unknown;
Nausea/vomiting: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Numbness or tingling: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Pain on breathing: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Palpitations: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Persistent dry cough: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Persistent fatigue: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Problems hearing: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Persistent headache: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Persistent muscle pain: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Post-exertional malaise: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Problems passing urine: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Problems seeing: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Problem swallowing: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Problems with balance: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Problems with gait/falls: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Reduced smell: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Reduced taste: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
 ringing in ears: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Seizures: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Shortness of breath: Yes, but not present anymore Yes, still present;
 If yes: Present At rest With activity; Yes, intermittent No Unknown;
Skin rash: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
 If yes, please tick all areas of the body that apply: Face Trunk (stomach or back) Arms Legs Buttocks
Toes Fingers;
Slowness of movement: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Sleeping less: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Sleeping more: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Stiffness of muscles: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Stomach pain: Yes, but not present anymore Yes still present Yes, intermittent No Unknown;
Swollen ankles: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Tremors: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Trouble in concentrating: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Weakness in limbs: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Weight loss: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
The following questions should not be completed for children <15yrs:
Erectile dysfunction: Yes, but not present anymore Yes, still present Yes, intermittent No Unknown;
Hallucinations (seeing or hearing things others don't see or hear): Yes, but not present anymore
Yes, still present Yes, intermittent No Unknown

PARTICIPANT ID³ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ |

Module 3: Clinical examinations, laboratory tests and diagnosis during follow up visit

 This module should be completed by a health worker to report on examinations/tests undertaken during the current follow up visit. **Date of follow up visit:** [D][D]/[M][M]/[Y][Y][Y][Y]

Country _____ City: _____ Facility name (if applies) _____

3.1 Neurological examination

 Was a neurological examination performed? Yes No Unknown;

 If yes, findings were: Normal Abnormal Unknown;

If abnormal, select below the abnormalities that apply:

 Aphasia: Yes No Unknown;

 Ataxia: Yes No Unknown;

 Confusion, disorientation or otherwise abnormal mental status: Yes No Unknown;

 Dysarthria: Yes No Unknown;

 Dystonia: Yes No Unknown;

 Facial weakness: Yes No Unknown;

 Hearing loss: Yes No Unknown;

 Hemiparesis: Yes No Unknown;

 Neuralgia: Yes No Unknown;

 Paraparesis: Yes No Unknown;

 Sensory Loss: Yes No Unknown;

 Tremor or abnormal movements: Yes No Unknown;

 Vision loss (including ocular, field cut): Yes No Unknown

3.2 Radiographic examinations

 Did the participant perform any radiographic examination? Yes No Unknown;

If yes, please specify type of exam and results:

 CT Scan Brain: Done Not done Unknown;

 If done: Normal Abnormal, likely unrelated to COVID-19 Abnormal, likely related to COVID-19 Abnormal, but unknown if related to COVID-19;

 CT Scan Chest: Done Not done Unknown;

 If done: Normal Abnormal, likely unrelated to COVID-19 Abnormal, likely related to COVID-19 Abnormal, but unknown if related to COVID-19;

 Echocardiogram: Done Not done Unknown;

 If done: Normal Abnormal, likely unrelated to COVID-19 Abnormal, likely related to COVID-19 Abnormal, but unknown if related to COVID-19;

 Lung ultrasound: Done Not done Unknown;

 If done: Normal Abnormal, likely unrelated to COVID-19 Abnormal, likely related to COVID-19 Abnormal, but unknown if related to COVID-19;

 MRI Brain: Done Not done Unknown;

 If done: Normal Abnormal, likely unrelated to COVID-19 Abnormal, likely related to COVID-19 Abnormal, but unknown if related to COVID-19;

 MRI Spine: Done Not done Unknown;

 If done: Normal Abnormal, likely unrelated to COVID-19 Abnormal, likely related to COVID-19 Abnormal, but unknown if related to COVID-19;

 X-ray Chest: Done Not done Unknown;

 If done: Normal Abnormal, likely unrelated to COVID-19 Abnormal, likely related to COVID-19 Abnormal, but unknown if related to COVID-19

³ Participant ID: obtain the 4-digit site code by contacting COVID_ClinPlatform@who.int. Enter a 5-digit patient number (e.g. 00001, 00002, etc) and record the information in a logbook

3.3 Blood tests

 Was a blood test done? Yes No Unknown;

If yes, specify type of test, date, and results from list below:

Albumin:	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> g/L <input type="checkbox"/> g/dL
ALT/SGPT:	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> IU/L
Antithyroglobulin:	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> IU/ml
AST/SGOT:	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> IU/L
Creatine Kinase MM:	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> IU/L <input type="checkbox"/> UKAT/L
Creatinine:	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> mg/dL <input type="checkbox"/> μmol/L
C-reactive protein (CRP):	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> mg/L
D-Dimer:	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> ng/mL <input type="checkbox"/> μg/L
Fasting Blood Glucose:	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> mg/dL
Ferritin:	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> ng/mL <input type="checkbox"/> μg/L
Fibrinogen:	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> g/L <input type="checkbox"/> mg/dL
Globular Filtration Rate:	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> ml/min
LDH:	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> IU/L
Lymphocytes:	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> cells/μL <input type="checkbox"/> cells/mm ³
Thyroid peroxidase antibodies:	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> U/ml
Troponin:	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> ng/mL <input type="checkbox"/> μg/L
TSH:	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> mU/L
Urea (BUN):	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> g/L <input type="checkbox"/> mg/dL <input type="checkbox"/> mmol/L
Coronavirus antibodies IgA:	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> Pos <input type="checkbox"/> Neg
Coronavirus antibodies IgG:	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> Pos <input type="checkbox"/> Neg
Coronavirus antibodies IgM:	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> Pos <input type="checkbox"/> Neg

3.4 Clinical Tests and Scales

 Was a neurological test done? Yes No Unknown;

If yes, specify type of test and results from list below:

Addenbrooke's Cognitive Examination-III (ACE-III): Done Not done Unknown;

If done, score 0-100 [][] [][];

Cerebral Spinal Fluid examination: Done Not done Unknown;

 If done: Normal Abnormal, likely unrelated to COVID-19 Abnormal, likely related to COVID-19

 Abnormal, unknown if related to COVID-19 Unknown;

Electroencephalogram: Done Not done Unknown;

 If done: Normal Abnormal, likely unrelated to COVID-19 Abnormal, likely related to COVID-19

 Abnormal, unknown if related to COVID-19 Unknown;

Electromyogram: Done Not done Unknown;

 If done: Normal Abnormal, likely unrelated to COVID-19 Abnormal, likely related to COVID-19

 Abnormal, unknown if related to COVID-19 Unknown;

Hearing test: Done Not done Unknown;

 If done: Normal Abnormal, likely unrelated to COVID-19 Abnormal, likely related to COVID-19

 Abnormal, unknown if related to COVID-19 Unknown;

Mini-Mental State Examination (MMSE): Done Not done Unknown;

If done: score 0-30 [][] [][];

Montreal Cognitive Assessment (MoCA): Done Not done Unknown;

If done: score 0-30 [][] [][];

Nerve Conduction Studies: Done Not done Unknown;

 If done: Normal Abnormal, likely unrelated to COVID-19 Abnormal, likely related to COVID-19

 Abnormal, unknown if related to COVID-19 Unknown;

Vision test: Done Not done Unknown;

 If done: Normal Abnormal, likely unrelated to COVID-19 Abnormal, likely related to COVID-19

 Abnormal, unknown if related to COVID-19 Unknown;

Other tests performed: Done Not done Unknown;

 If done: Name of the test _____ **Results:** Normal Abnormal Unknown

3.4 Clinical Tests and Scales *continuation*

Was a cardiovascular test done? Yes No Unknown;

If yes, specify type of test and results from list below:

Electrocardiogram: Done Not done Unknown;

If done: Normal Abnormal;

6-Minute Walking Distance: Done Not done;

If done: [][] metres;

Pulse rate at rest: [][] beats/minute Unknown;

Other tests performed: Done Not done Unknown;

If done: Name of the test _____ **Results:** Normal Abnormal Unknown

Was a pulmonary test done? Yes No Unknown;

If yes, specify type of test and results from list below:

Diffusing Capacity for Carbon Monoxide (DCLo) test: Done Not done; If done, [][] %;

Is the patient receiving supplemental oxygen? Yes No Unknown;

MRC dyspnoea scale: Score 1 Score 2 Score 3 Score 4 Score 5 Unknown;

Pulmonary Function Test: Done Not done Unknown;

If done: results Normal Abnormal; If abnormal: FVC _____ mL, FEV1 _____ mL;

Respiratory rate: [][] breaths/minute; **SPO₂:** [][] % Unknown;

Other tests performed: Done Not done Unknown;

If done: Name of the test _____ **Results:** Normal Abnormal

Was a gastrointestinal test done? Yes No Unknown;

If yes, specify type of test and results below:

Dysphagia Severity Scale: Done Not done Unknown;

If done: Score 1 Score 2 Score 3 Score 4 Score 5 Score 6 Score 7 Unknown;

Other tests performed: Done Not done Unknown;

If done: Name of the test _____ **Results:** Normal Abnormal

Was a musculoskeletal test done? Yes No Unknown;

If yes, specify type of test and results from list below:

Hand grip strength: Done Not done Unknown;

If done: [][] Newton OR [][] /Kg;

MRC Sum Score: Done Not done Unknown;

If done: score between 0-60 [][];

Timed up and go: Done Not done Unknown;

If done: time taken [][] seconds;

Other tests performed: Done Not done Unknown;

If done: Name of the test _____ **Results:** Normal Abnormal

Was any test done for fatigue/pain/activities of daily living? Yes No Unknown;

If yes, specify type of test and results from list below:

Barthel Index Score: Done Not done Unknown;

If done: score between 0-100 [][];

EQ5D-5L: Done Not done Unknown;

If done: score between 11111-55555 [][] [][];

Fatigue Numerical Rating Scale: Done Not done Unknown;

If done: score between 0-10 [][];

Fatigue Severity Scale: Done Not done Unknown;

If done: score between 1-7 [][];

Pain Numerical Rating Scale: Done Not done Unknown;

If done: score between 0-10 [][];

Other tests performed: Done Not done Unknown;

If done: Name of the test _____ **Results:** Normal Abnormal

3.4 Clinical Tests and Scales *continuation*

Was a mental health test done? Yes No Unknown;

If yes, specify type of test and results below:

Hospital Anxiety and Depression Scale: Done Not done Unknown;

If done: score between 0-21 [][];

Impact of Event Scale-Revised: Done Not done Unknown;

If done: score between 0-88 [][];

Patient Health Questionnaire-9 for depression (PHQ-9 for depression): Done Not done Unknown;

If done: score between 0-27 [][];

PTSD Checklist-5: Done Not done Unknown;

If done: score between 0-80 [][];

Other tests performed: Done Not done Unknown;

If done: Name of the test _____ **Results:** Normal Abnormal

Other test performed: Done Not done Unknown;

If done: Name of the test _____ **Results:** Normal Abnormal

3.5 New diagnosis of illness or complication related to COVID-19

Was the participant newly diagnosed with any illness or complication related to COVID-19 during this visit?

Cardiovascular: Yes No Unknown; **If yes**, please specify diagnosis from the list below:

Acute heart failure: Yes No Unknown;

Atrial arrhythmia: Yes No Unknown;

Arterial thrombosis: Yes No Unknown;

Chronic heart failure: Yes No Unknown;

Coronary aneurysms: Yes No Unknown;

Deep vein thrombosis: Yes No Unknown;

Deterioration of prior chronic heart failure: Yes No Unknown;

Ischemic cardiomyopathy: Yes No Unknown;

Left ventricular diastolic dysfunction: Yes No Unknown;

Myocarditis: Yes No Unknown;

Pericarditis: Yes No Unknown;

Right ventricular dysfunction: Yes No Unknown;

Ventricular arrhythmia: Yes No Unknown;

Other cardiovascular: Yes No Unknown; if Yes, specify _____

Dermatological: Yes No Unknown; **If yes**, please specify diagnosis from the list below:

COVID toes (lumpy lesions on toes): Yes No Unknown;

Skin rash: Yes No Unknown;

Other dermatological: Yes No Unknown; if Yes, specify _____

Endocrine: Yes No Unknown; **If yes**, please specify diagnosis from the list below:

Hypothyroidism: Yes No Unknown;

Low insulin sensitivity: Yes No Unknown;

Thyroiditis: Yes No Unknown;

Other endocrine: Yes No Unknown; if Yes, specify _____

Gastro-intestinal: Yes No Unknown; **If yes**, please specify diagnosis from the list below:

Deterioration of prior chronic liver failure: Yes No Unknown;

Dysphagia: Yes No Unknown;

Gastrointestinal haemorrhage: Yes No Unknown;

Post-infectious Irritable Bowel Syndrome: Yes No Unknown;

Other gastrointestinal: Yes No Unknown; if Yes, specify _____

Generic: Yes No Unknown; **If yes**, please specify diagnosis from the list below:

Exertional fatigue: Yes No Unknown;

Post viral fatigue syndrome: Yes No Unknown;

Other generic: Yes No Unknown; if Yes, specify _____

3.5 New diagnosis of illness or complication related to COVID-19 continuation

Musculoskeletal: Yes No Unknown; **If yes,** please specify diagnosis from the list below:

Arthralgia: Yes No Unknown;

Arthritis: Yes No Unknown;

ICU acquired weakness: Yes No Unknown;

Myalgia: Yes No Unknown;

Myositis: Yes No Unknown;

Muscle atrophy: Yes No Unknown;

Muscle weakness: Yes No Unknown;

Osteopenia: Yes No Unknown;

Osteoporosis: Yes No Unknown;

Secondary sarcopenia: Yes No Unknown;

Other musculoskeletal: Yes No Unknown; if Yes, specify _____

Mental health: Yes No Unknown; **If yes,** please specify diagnosis from the list below:

Anxiety: Yes No Unknown;

Depression: Yes No Unknown;

Post-traumatic Stress Disorder: Yes No Unknown;

Psychosis: Yes No Unknown;

Sleep disorder: Yes No Unknown;

Other mental: Yes No Unknown; if Yes, specify _____

Neurological: Yes No Unknown; **If yes,** please specify diagnosis from the list below:

Demyelinating or other inflammatory white matter brain lesions: Yes No Unknown;

Dementia/other neurocognitive disorder: Yes No Unknown;

Dysautonomia: Yes No Unknown;

Encephalitis: Yes No Unknown;

Headache: Yes No Unknown;

Hearing impairment: Yes No Unknown;

Hemorrhagic Stroke: Yes No Unknown;

Hypoxic ischemic brain injury: Yes No Unknown;

Intracerebral haemorrhage: Yes No Unknown;

Intraventricular haemorrhage: Yes No Unknown;

Ischemic Stroke: Yes No Unknown;

Meningitis: Yes No Unknown;

Movement Disorder: Yes No Unknown;

Motor Neuron Disease: Yes No Unknown;

Myelopathy/Spinal Cord Disease: Yes No Unknown;

Myopathy: Yes No Unknown;

Neuromuscular Disorders: Yes No Unknown;

Neuromuscular junction disorder: Yes No Unknown;

Non-traumatic subarachnoid haemorrhage: Yes No Unknown;

Polyneuropathy: Yes No Unknown;

Polyradiculoneuropathy (GBS): Yes No Unknown;

Psychiatric disorder: Yes No Unknown;

Plexopathy: Yes No Unknown;

Radiculopathy: Yes No Unknown;

Seizures/Epilepsy: Yes No Unknown;

Toxic/Metabolic Encephalopathy: Yes No Unknown;

Vision impairment: Yes No Unknown;

Other neurological: Yes No Unknown; if Yes, specify _____

Pulmonary: Yes No Unknown; **If yes,** please specify diagnosis from the list below:

Bronchiectasis: Yes No Unknown;

Cystic changes: Yes No Unknown;

Deterioration of prior chronic pulmonary disease: Yes No Unknown;

Lung fibrosis: Yes No Unknown;

Lung hypoperfusion: Yes No Unknown;

Mixed restrictive and obstructive pulmonary disease: Yes No Unknown;

Obstructive pulmonary disease: Yes No Unknown;

Pleural lesions: Yes No Unknown;

Pulmonary arterial hypertension: Yes No Unknown;

Pulmonary embolism: Yes No Unknown;

Restrictive pulmonary disease: Yes No Unknown;

Other pulmonary: Yes No Unknown; if Yes, specify _____

Renal: Yes No Unknown; **If yes,** please specify diagnosis from the list below:

Chronic renal failure: Yes No Unknown;

Deterioration of prior chronic renal failure: Yes No Unknown;

Other renal: Yes No Unknown; if Yes, specify _____