Inclusion

Record ID (patient identifier)

_____

Hospital based surveillance of COVID-19 cases in Switzerland

Patient-level information

Each new record is a distinct COVID-19 Episode related to a patient.
In case a specific patient undergoes more than one episode, please create a new record to report each additional episode.

Is this another COVID-19 episode from a same patient ?

◯ No (this is the patient's first episode)
◯ Yes (the first episode record has been already reported)
◯ Still to be confirmed

ID of first episode of this patient

ID is the number on the right of the full CenterID-ID
identifier, e.g. 123-456

([0-9999])   _____

Center (or consortium) where the first episode was
created

◯ CHUV (Lausanne)   ◯ EOC (Lugano)
◯ HFR (Fribourg)   ◯ Hirslanden AG ZH
 (Zurich)   ◯ Hopital VS (Sion)
◯ HUG (Geneva)   ◯ Inselspital (Bern)
◯ KISPI (Basel)   ◯ KISPI (Zurich)
◯ KSA (Aarau)   ◯ KSGR (Graubuenden)
◯ KSNW (Niedwalden)   ◯ KSSG (St.Gallen) &
 consortium   ◯ KSW (Winterthur)
◯ LUKS (Luzern)   ◯ OKS (St.Gallen)
◯ Spitaeler SH (Schaffhausen)
◯ STGAG KSM (Muensterlingen)
◯ USB (Basel)   ◯ USZ (Zurich)
(your current center: [user-dag-label])

Checking inclusion criteria

Hospitalised for more than 24 hours	◯ Yes ◯ No
Laboratory-confirmed COVID-19 diagnosis	◯ Yes ◯ No

Patient's inclusion

Confirm inclusion ?	☐ Yes (include patient)
Inclusion date	_____
ID of user checking the inclusion	_____
Current date	◯ 2020-11-16 ((last date form is saved))

Demography

Demography	
Year of birth	_____
Is the patient 6 years old or less ?	○ No ○ Yes
Birth Month	_____
Gender	○ Male ○ Female ○ Other

Height, Weight and BMI will be evaluated during each individual hospitalisation event

Case Declaration

Starting date of COVID-19 symptoms

_____

Exposure factors

Type of exposure
- ◯ Community acquired
- ◯ Nosocomial (> 5 days)
- ◯ Unknown

Where was the patient contaminated?
- ◯ Household
- ◯ School / Kindergarten /Daycare
- ◯ Unknown

Employed in a healthcare facility ?
- ◯ No
- ◯ Yes
- ◯ Unknown

Employed in a microbiology laboratory?
- ◯ No
- ◯ Yes
- ◯ Unknown

Sample

Date and time of lab sample collection

_____

...check if date/time of sample may NOT be exact
- ◯ exact date and time
- ◯ exact date / estimated time
- ◯ estimated date and time
 (optional)

Type of sample
- ◯ Nasal swab
- ◯ Throat swab
- ◯ Nasopharyngeal swab
- ◯ Tracheal aspiration
- ◯ Broncho-alveolar lavage
- ◯ Other...

...please, specify sample type

_____

In which service was the sample taken ?
- ◯ Medicine
- ◯ Geriatrics
- ◯ Intensive Care
- ◯ Surgery
- ◯ Paediatrics
- ◯ Emergency Room
- ◯ Other...

...please, specify where the sample was taken

_____

Laboratory confirmation method	◯ RT-PCR ◯ Other...

...please, specify confirmation method	_____

Was there another sample taken for laboratory testing?	◯ No ◯ Yes

Second sample

Date and time of lab sample collection	_____

...check if date/time of sample may NOT be exact	◯ exact date and time ◯ exact date / estimated time ◯ estimated date and time (optional)

Type of sample	◯ Nasal swab ◯ Throat swab ◯ Nasopharyngeal swab ◯ Tracheal aspiration ◯ Broncho-alveolar lavage ◯ Other...

...please, specify sample type	_____

In which service was the sample taken ?	◯ Medicine ◯ Geriatrics ◯ Intensive Care ◯ Surgery ◯ Paediatrics ◯ Emergency Room ◯ Other...

...please, specify where the sample was taken	_____

Laboratory confirmation method	◯ RT-PCR ◯ other...

...please, specify confirmation method	_____

Laboratory test result	◯ Positive ◯ Negative

Was there another sample taken for laboratory testing?	◯ No ◯ Yes

Third sample

Date and time of lab sample collection

_____

...check if date/time of sample may NOT be exact
- ◯ exact date and time
- ◯ exact date / estimated time
- ◯ estimated date and time
  (optional)

Type of sample
- ◯ Nasal swab
- ◯ Throat swab
- ◯ Nasopharyngeal swab
- ◯ Tracheal aspiration
- ◯ Broncho-alveolar lavage
- ◯ Other...

...please, specify sample type

_____

In which service was the sample taken ?
- ◯ Medicine
- ◯ Geriatrics
- ◯ Intensive Care
- ◯ Surgery
- ◯ Paediatrics
- ◯ Emergency Room
- ◯ Other...

...please, specify where the sample was taken

_____

Laboratory confirmation method
- ◯ RT-PCR
- ◯ Other...

...please, specify confirmation method

_____

Laboratory test result
- ◯ Positive
- ◯ Negative

Was there another sample taken for laboratory testing?
- ◯ No
- ◯ Yes

Fourth sample

Date and time of lab sample collection

_____

...check if date/time of sample may NOT be exact
- ◯ exact date and time
- ◯ exact date / estimated time
- ◯ estimated date and time
  (optional)

Type of sample	◯ Nasal swab ◯ Throat swab ◯ Nasopharyngeal swab ◯ Tracheal aspiration ◯ Broncho-alveolar lavage ◯ Other...
...please, specify sample type	_____
In which service was the sample taken ?	◯ Medicine ◯ Geriatrics ◯ Intensive Care ◯ Surgery ◯ Paediatrics ◯ Emergency Room ◯ Other...
...please, specify where the sample was taken	_____
Laboratory confirmation method	◯ RT-PCR ◯ Other...
...please, specify confirmation method	_____
Laboratory test result	◯ Positive ◯ Negative

Admission

Please confirm that the patient is rehospitalised
following complications of this same COVID-19episode!

☐ same COVID-19 episode

Entry date in the hospital

_____

Patient's admission

Where was the patient hospitalised ?

○ Medicine
○ Geriatrics
○ Intensive Care
○ Surgery
○ Paediatrics
○ Emergency Room
○ Other...

...please, specify where he/she has been diagnosed

_____

Was the patient hospitalised in an unit dedicated to COVID-19)

○ No
○ Yes
○ Unknown

[Only applicable for hospital consortia]

If admission didn't occur in the main hospital of your consortium, please provide the ID of the subsidiary hospital in your consortium

○ 2
○ 3
○ 4
○ 5
○ 6
○ 7
○ 8
○ 9
 ((optional))

...code of Unit/Building

_____
(optional)

Origin (pre-hospitalisation)

○ Domicile
○ Long term care
○ Other hospital
○ Other...

...please, specify origin

_____

Was the patient in contact with a healthcare personnel prior to hospitalisation (by phone or consultation) ?

○ Yes
○ No
○ Unknown

Height and Weight during hospitalisation

Height

previously reported height (if applicable):
[height][previous-instance]

_____
([cm])

Weight

_____
([kg])

BMI

_____
([kg/m2])

Obesity

◯ No   ◯ Yes   ◯ Unknown

This is only a warning message:
the BMI calculation and obesity status do not match.
Please check the given values.

Note that the WHO classification based on BMI is lacking subtleties, so this warning is only present to raise awareness on a possible error. It does not imply that there is indeed an error.

Symptoms

Severity (CURB-65 score)

☐ Confusion (abbreviated Mental Test Score < 9)
☐ Urea (BUN > 19 mg/dL or 7 mmol/L)
☐ Respiratory rate > 30 per minute
☐ Blood pressure: diastolic < 60 or systeolic < 90 mmHg
☐ Age >= 65 years
☐ None of the above

Severity (for children)

☐ Respiratory distress
☐ Oxygen saturation < 92%
☐ Evidence of severe clinical dehydration or clinical shock
☐ Altered conscious level
☐ None of the above

Total score (each choice counts for 1)

_____
(0-1 points: low risk >1 points: high risk)

Additional symptoms

☐ Cough
☐ Rhinitis
☐ Diarrhoea
☐ Fever
☐ None of the above

What was the highest temperature recorded?

_____
(in degrees celsius)

Clinical Complementary Information

Co-morbidities

Usual good health (no co-morbidities)

◯ No　◯ Yes

Chronic respiratory disease	◯ No	◯ Yes	◯ Unknown

... please specify

_____

Asthma	◯ No	◯ Yes	◯ Unknown
Diabetes	◯ No	◯ Yes	◯ Unknown
Hypertension	◯ No	◯ Yes	◯ Unknown
Chronic cardiovascular disease	◯ No	◯ Yes	◯ Unknown
Chronic renal disease	◯ No	◯ Yes	◯ Unknown
Chronic liver disease	◯ No	◯ Yes	◯ Unknown
Chronic neurological impairment	◯ No	◯ Yes	◯ Unknown
Hematological pathology with immuno-suppression	◯ No	◯ Yes	◯ Unknown
Oncological pathologies	◯ No	◯ Yes	◯ Unknown
Rheumatological pathology with immuno-suppression	◯ No	◯ Yes	◯ Unknown
Dementia	◯ No	◯ Yes	◯ Unknown
Transplant (solid organs)	◯ No	◯ Yes	◯ Unknown
HIV-positive	◯ No	◯ Yes	◯ Unknown
Immuno-suppressive treatment	◯ No	◯ Yes	◯ Unknown
Tuberculosis	◯ No	◯ Yes	◯ Unknown
Others	◯ No	◯ Yes	◯ Unknown

.... please specify

_____

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Other risk factors

Pregnancy	○ No ○ Yes ○ Unknown
Postpartum < 4 weeks	○ No ○ Yes ○ Unknown (Women who gave birth in the 4 weeks before the COVID-19 episode)
Premature < 24 months	○ No ○ Yes ○ Unknown (Premature children aged < 24 months)
...please specify the gestational week the child was born in	_____ (Number between 0 and 38)
...please specify weight at birth	_____ (in kg)
Smoking	○ No ○ Yes ○ Unknown
Is the patient under an ACE inhibitor?	○ No ○ Yes ○ Unknown
Was the patient prescribed or treated with cardiovascular medications (during or prior to hospitalisation)?	○ No ○ Yes ○ Unknown
Charlson Comorbidity Index (CCI) [mdcalc Calculator] Charlson M, Szatrowski TP, Peterson J, Gold J. Validation of a combined comorbidity index. J Clin Epidemiol. 1994;47(11):1245-51. PMID: 7722560	_____

Antiviral treatment (against COVID-19)

Prophylactic treatment (against COVID-19)	○ No ○ Yes ○ Unknown
Treatment of confirmed infection (against COVID-19)	○ No ○ Yes ○ Unknown
Name of the treatment	☐ Chloroquin ☐ Interferon ☐ Lopinavir/Ritonavir ☐ Remdesivir ☐ Tenofovir ☐ Ribavirin ☐ Other...
...please, specify (name of treatment)	_____
Starting date of the treatment	_____ ((if available))

Ending date of the treatment

_____
((if available))

Stay in Intermediate care

Did the patient stay in intermediate care ?

◯ No   ◯ Yes   ◯ Unknown

Intermediate care (first stay)

Intermediate care entry date

_____
((if available))

Intermediate care exit date

_____
((if available))

Non-invasive ventilation	◯ No ◯ Yes ◯ Unknown
Any additional stay in intermediate care to report ?	◯ No ◯ Yes

Intermediate care (second stay)

Intermediate care entry date

_____
((if available))

Intermediate care exit date

_____
((if available))

Non-invasive ventilation	◯ No ◯ Yes ◯ Unknown
Any additional stay in intermediate care to report ?	◯ No ◯ Yes

Intermediate care (third stay)

Intermediate care entry date

_____
((if available))

Intermediate care exit date

_____
((if available))

Non-invasive ventilation	◯ No ◯ Yes ◯ Unknown

Stay in Intensive care

Did the patient stay in intensive care ?

◯ No   ◯ Yes   ◯ Unknown

Intensive care (first stay)

Intensive care entry date	
	_____ ((if available))
Intensive care exit date	
	_____ ((if available))
Non-invasive ventilation	◯ No ◯ Yes ◯ Unknown
Invasive ventilation	◯ No ◯ Yes ◯ Unknown
Extra-Corporeal Membrane Oxygenation (ECMO)	◯ No ◯ Yes ◯ Unknown
Any additional stay in intensive care to report ?	◯ No ◯ Yes

Intensive care (second stay)

Intensive care entry date	
	_____ ((if available))
Intensive care exit date	
	_____ ((if available))
Non-invasive ventilation	◯ No ◯ Yes ◯ Unknown
Invasive ventilation	◯ No ◯ Yes ◯ Unknown
Extra-Corporeal Membrane Oxygenation (ECMO)	◯ No ◯ Yes ◯ Unknown
Any additional stay in intensive care to report ?	◯ No ◯ Yes

Intensive care (third stay)

Intensive care entry date

_____
((if available))

Intensive care exit date

_____
((if available))

Non-invasive ventilation	◯ No ◯ Yes ◯ Unknown
Invasive ventilation	◯ No ◯ Yes ◯ Unknown
Extra-Corporeal Membrane Oxygenation (ECMO)	◯ No ◯ Yes ◯ Unknown

Complications
(probably related to COVID-19)

Did the patient have any complications ?

◯ No   ◯ Yes   ◯ Unknown

Ear/Nose/Throat (ENT) diseases	◯ No ◯ Yes ◯ Unknown
Acute Otitis Media	◯ No ◯ Yes ◯ Unknown
Respiratory diseases	◯ No ◯ Yes ◯ Unknown
Acute respiratory distress syndrome	◯ No ◯ Yes ◯ Unknown
Pneumonia	◯ No ◯ Yes ◯ Unknown
...pneumonia code [see pneumonia classification]	◯ PN1 ◯ PN2 ◯ PN3 ◯ PN4 ◯ PN5 ◯ Lobar pneumonia ◯ Other
...was the pneumonia associated with COVID-19?	◯ No ◯ Yes ◯ Unknown
Cardiac disease	◯ No ◯ Yes ◯ Unknown
Digestive disease	◯ No ◯ Yes ◯ Unknown
Liver disease	◯ No ◯ Yes ◯ Unknown
Renal disease	◯ No ◯ Yes ◯ Unknown
Neurological impairment	◯ No ◯ Yes ◯ Unknown

Osteo-articular disease	◯ No ◯ Yes ◯ Unknown
Thrombosis/Embolism	◯ No ◯ Yes ◯ Unknown
Other bacterial infections (excepted pneumonia)	◯ No ◯ Yes ◯ Unknown
Other non-bacterial infections	◯ No ◯ Yes ◯ Unknown
Other complications...	◯ No ◯ Yes
...please, specify (complications)	_____

Antibiotic treatment (against complications)

Antibiotic treatment taken (against complications)	◯ No ◯ Yes ◯ Unknown
Code of given antibiotics (main) [see list of AB codes]	_____ ([code required - 0 if n/a])
Code of given antibiotics (additional)	_____ ([optional])
Code of given antibiotics (additional)	_____ ([optional])
Code of given antibiotics (additional)	_____ ([optional])
Code of given antibiotics (additional)	_____ ([optional])
Antifungal treatment taken (against complications)	◯ No ◯ Yes ◯ Unknown
Cortico-steroids treatment taken (against complications)	◯ No ◯ Yes ◯ Unknown

Patient Follow Up

Transfers

Was the patient transferred during hospitalisation?	○ Yes ○ No ○ Unknown

... the patient was transferred in

☐ Medicine
☐ Geriatrics
☐ Intensive Care
☐ Surgery
☐ Paediatrics
☐ Others...

... please specify (one item only)

_____

Patient's destination

Deceased	○ Yes ○ No ○ Unknown

... death occured

○ during hospitalisation
○ after being discharged

Date of death

_____

Was the death caused by COVID-19?	○ No ○ Yes ○ Unknown

Destination

○ Domicile
○ LTC Facility
○ Another hospital
○ Other
○ Unknown

... please specify destination

_____

Was the patient transferred to an hospital participating to this surveillance system?	○ No ○ Yes

In which participating hospital was the patient transferred? Make sure you give the patient ID to the hospital he/she is being transferred to in order to ease the follow-up process!	○ CHUV (Lausanne) ○ EOC (Lugano) ○ HFR (Fribourg) ○ Hirslanden AG ZH (Zurich) ○ Hopital VS (Sion) ○ HUG (Geneva) ○ Inselspital (Bern) ○ KISPI (Basel) ○ KISPI (Zurich) ○ KSA (Aarau) ○ KSGR (Graubuenden) ○ KSNW (Niedwalden) ○ KSSG (St.Gallen) & consortium ○ KSW (Winterthur) ○ LUKS (Luzern) ○ OKS (St.Gallen) ○ Spitaeler SH (Schaffhausen) ○ STGAG KSM (Muensterlingen) ○ USB (Basel) ○ USZ (Zurich)
Why was the patient transferred to another hospital?	○ Lack of space ○ Favourable evolution (the patient was put in recovery care) ○ Unfavourable evolution (the patient needed to be put in intensive care) ○ Unknown
Discharging date from hospital	_____
Did the patient leave with any sequelae requiring post-discharge treatment?	○ Yes ○ No ○ Unknown

Comments

Comments

_____

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