The WHO has established a Global Clinical Data Platform\(^1\) 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 website\(^1\) 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.

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\(^1\) https://www.who.int/teams/health-care-readiness-clinical-unit/covid-19/data-platform
Module 1: Background demographical and epidemiological information

This module is completed by ☐ patient ☐ caregiver (in case of children) ☐ health care worker.
Facility name of follow up visit (if applies) ____________________________ Country ____________________________
Date of module 1 completion: [D] [D] [M] [M] [Y] [Y] [Y] [Y]

1.1 Acute episode of COVID-19 information (first episode, in case of re-infection)

Does the patient have a WHO Rapid Core CRF Participant ID?
If Yes, report PARTICIPANT ID of CORE CRF ____________________________

1.2 Demographics

Sex at Birth: Male Female Not specified
Age: [ ] [ ] [ ] years; OR [ ] [ ] months [ ] [ ] days
Height (Length): [ ] [ ] [ ] cm
Weight: [ ] [ ] [ ] kg

Highest level of education completed? No schooling or never completed any grade
Elementary school Vocational school Secondary school University

In the last 3 years, has the participant ever stayed overnight in a hospital, rehabilitation facility, or long-term care facility?
Yes, a hospital Yes, a rehabilitation facility Yes, a long-term care facility
All No Unknown

Was the participant a long-term-care facility resident prior to initial COVID-19 diagnosis?
Yes No Unknown

Ethnicity/background: Asian Black White Mixed Arab Latino Other Unknown

Smoking: Current Former Never Unknown

Substance abuse: Yes No Unknown; If yes: Alcohol Drug Other

Was this participant employed as a health care worker or laboratory staff since Jan 1st, 2020?
Yes No Unknown

Pregnancy information

Was the participant pregnant during the acute illness of COVID-19?
Yes No Unknown; If yes, gestational weeks at COVID-19 diagnosis/clinical suspicion: [ ] [ ] [ ] weeks Unknown;
If pregnant during the acute illness, outcome of pregnancy?: Miscarriage Induced abortion Still birth Live birth Still pregnant;
If pregnant during the acute illness, and currently not pregnant: gestational age at the time of delivery/abortion?
[ ] [ ] weeks;
If delivered, mode of delivery?: Vaginal Assisted vaginal Caesarean section;
Is the participant currently pregnant?
Yes No Unknown; If yes, gestational weeks [ ] [ ] Weeks Unknown;
If recently pregnant, is the participant currently breastfeeding?
Yes No Unknown

1.3 Pre-existing conditions in the year prior to your acute illness of COVID-19:

In the year prior to the acute illness of COVID-19, has the participant been diagnosed with any of the following conditions?

Asplenia: Yes No Unknown;
Cancer: Yes No Unknown;
Chronic heart disease (not hypertension): Yes No Unknown;
Chronic kidney disease: Yes No Unknown;
Chronic liver disease: Yes No Unknown;
Chronic lung disease: Yes No Unknown;
Chronic neurological disorder: Yes No Unknown;
If Yes, specify: Dementia Stroke Multiple Sclerosis Parkinson’s Disease;
Diabetes: Yes No Unknown;
HIV: Yes No Unknown; If Yes, was on ART? Yes No Unknown;
If Yes, what regimen? Protease inhibitor-based ART; NNRTI-based ART Integrase inhibitor-based ART; Last viral load test: ________ copies/ml; Last CD4 cell count: [ ] [ ] [ ] cells/mm³;
Hypertension: Yes No Unknown;
If Yes, did the participant receive medication? Yes No Unknown;
Immunodeficiency: Yes No Unknown;
Mental health conditions: Yes No Unknown.
If Yes, specify: psychoses depression anxiety;
Obesity (BMI>30): Yes No Unknown;
Tuberculosis: Yes No Unknown; If yes Active Previous;
Any other condition: Yes No; If yes, specify________________________
1.4 Diagnosis of acute illness of COVID-19 (first episode, in case of re-infection)

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 receive a PCR test during the acute illness?
Yes ☐ positive, 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, 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, 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

<table>
<thead>
<tr>
<th>WHO Clinical Classification</th>
<th>Based on available clinical records</th>
<th>Based on self-report, if clinical records are not available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>No hypoxia or pneumonia</td>
<td>Did not receive oxygen</td>
</tr>
<tr>
<td>Moderate</td>
<td>Clinical signs of non-severe pneumonia AND SpO2&lt;90% on room air</td>
<td>Received oxygen (or told you they needed it, but it was not available)</td>
</tr>
<tr>
<td>Severe</td>
<td>Adults/adolescents: Clinical signs of severe pneumonia AND SpO2 &lt;90% on room air; OR RR &gt; 30 breaths/min Children: Clinical signs of severe pneumonia AND at least one of the following: central cyanosis; OR SpO2 &lt; 90%; OR severe respiratory distress (e.g. fast breathing, grunting, very severe chest indrawing); OR general danger sign(s) (inability to breastfeed or drink, lethargy or unconsciousness, convulsions)</td>
<td>Received invasive ventilation (or max available respiratory support)</td>
</tr>
<tr>
<td>Critical</td>
<td>ARDS; OR sepsis/septic shock; OR pulmonary embolism, acute coronary syndrome, acute stroke; OR Multi-Inflammatory Syndrome in Children and adolescents temporally related to COVID-19</td>
<td></td>
</tr>
</tbody>
</table>

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

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: I__I I__I I__I I__I 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 breathes 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 ☐ Unknown;
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 4th generation Cephalosporins (e.g. ceftriaxone, cefotaxime, cefazidime, cefepime) ☐ Carbapenems (e.g imipenem, meropenem) ☐ Piperacillin + Tazobactam ☐ Amoxicillin-clavulanate ☐ Cotrimoxazole ☐ Other antibiotics __________________________; Duration of antibiotics therapy (days): [D] [D] [D] [D];

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

| Blood-derived products received? | Yes | No | Unknown | 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 |

<table>
<thead>
<tr>
<th>Experimental agents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ivermectin received?</td>
</tr>
<tr>
<td>Interferon received?</td>
</tr>
<tr>
<td>Eculizumab received?</td>
</tr>
<tr>
<td>Pyotherapy received?</td>
</tr>
<tr>
<td>IL-1 Antagonists received?</td>
</tr>
<tr>
<td>IL-6 Antagonists received?</td>
</tr>
<tr>
<td>Kinase Inhibitors received?</td>
</tr>
<tr>
<td>Neutralizing monoclonal antibodies received?</td>
</tr>
<tr>
<td>Other agents:</td>
</tr>
</tbody>
</table>

| Steroids received? | Yes | No | Unknown; If yes specify: Dexamethasone Hydrocortisone Prednisone Methylprednisolone Other __________________________ |

| Duration of steroid therapy (days): | [ ] [ ] | Dose: | Route: ☐ Oral ☐ Intravenous ☐ Inhaled |
Module 2. Follow up interview

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

Date of follow up interview: [ _D_ ] [ _D_ ] [ _M_ ] [ _M_ ] [ _Y_ ] [ _Y_ ] [ _Y_ ] [ _Y_ ]

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 admission: [ _D_ ] [ _D_ ] [ _M_ ] [ _M_ ] [ _Y_ ] [ _Y_ ] [ _Y_ ] [ _Y_ ]

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: [ _D_ ] [ _D_ ] [ _M_ ] [ _M_ ] [ _Y_ ] [ _Y_ ] [ _Y_ ] [ _Y_ ]

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: [ _D_ ] [ _D_ ] [ _M_ ] [ _M_ ] [ _Y_ ] [ _Y_ ] [ _Y_ ] [ _Y_ ]

Product name of COVID-19 vaccine dose 2:

- Moderna
- Pfizer-BioNTech
- AstraZeneca
- Janssen
- Novavax
- Other ☐ Unknown ☐

Date of vaccine dose 2: [ _D_ ] [ _D_ ] [ _M_ ] [ _M_ ] [ _Y_ ] [ _Y_ ] [ _Y_ ] [ _Y_ ]

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 ☐

2.5 Functioning (do not need complete this section for children <15yrs)

Ability to self-care: Same as before COVID-19 ☐ Worse ☐ Better ☐ 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?

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 ☐

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

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 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

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:

<table>
<thead>
<tr>
<th><strong>Symptom</strong></th>
<th><strong>Yes</strong></th>
<th><strong>No</strong></th>
<th><strong>Intermittent</strong></th>
<th><strong>Unknown</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anxiety</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Behaviour change</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Can't move and/or feel one side of body or face</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Chest pain</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Constipation</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Depressed mood</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Diarrhoea</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Dysmenorrhoea</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Dizziness/light headedness</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Fainting/blackouts</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Fever</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Forgetfulness</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Jerking of limbs</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Joint pain/swelling</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Loss of appetite</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Loss of interest/pleasure</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Lumpy lesions: (purple/pink/bluish) on toes/COVID toes</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Nausea/vomiting</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Numberness or tingling</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Pain on breathing</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Palpitations</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Persistent dry cough</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Persistent fatigue</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Problems hearing</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Persistent headache</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Persistent muscle pain</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Post-exertional malaise</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Problems passing urine</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Problems seeing</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Problem swallowing</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Problems with balance</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Problems with gait/falls</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Reduced smell</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Reduced taste</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Ringing in ears</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Seizures</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Shortness of breath</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>If yes:</strong></td>
<td><strong>Present At rest With activity:</strong></td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
<td></td>
</tr>
<tr>
<td><strong>Skin rash:</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>If yes, please tick all areas of the body that apply:</strong></td>
<td><strong>Face</strong></td>
<td><strong>Trunk (stomach or back)</strong></td>
<td><strong>Arms</strong></td>
<td><strong>Legs</strong></td>
</tr>
<tr>
<td><strong>Slowness of movement</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Sleeping less</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Sleeping more</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Stiffness of muscles</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Stomach pain</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Swollen ankles</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Tremors</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Trouble in concentrating</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Weakness in limbs</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
<tr>
<td><strong>Weight loss</strong></td>
<td>Yes, but not present anymore</td>
<td>Yes, still present</td>
<td>Yes, intermittent</td>
<td>No Unknown</td>
</tr>
</tbody>
</table>

**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 |
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__] [__M__] [__Y__] [__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:

<table>
<thead>
<tr>
<th>Test</th>
<th>Done</th>
<th>Not done</th>
<th>Value:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albumin:</td>
<td></td>
<td></td>
<td>g/L g/dL</td>
</tr>
<tr>
<td>ALT/SGPT:</td>
<td></td>
<td></td>
<td>IU/L</td>
</tr>
<tr>
<td>Antithyroglobulin:</td>
<td></td>
<td></td>
<td>IU/ml</td>
</tr>
<tr>
<td>AST/SGOT:</td>
<td></td>
<td></td>
<td>IU/L</td>
</tr>
<tr>
<td>Creatine Kinase MM:</td>
<td></td>
<td></td>
<td>IU/L</td>
</tr>
<tr>
<td>Creatinine:</td>
<td></td>
<td></td>
<td>mg/dL μmol/L</td>
</tr>
<tr>
<td>C-reactive protein (CRP):</td>
<td></td>
<td></td>
<td>mg/L</td>
</tr>
<tr>
<td>D-Dimer:</td>
<td></td>
<td></td>
<td>ng/mL μg/L</td>
</tr>
<tr>
<td>Fasting Blood Glucose:</td>
<td></td>
<td></td>
<td>mg/dL</td>
</tr>
<tr>
<td>Ferritin:</td>
<td></td>
<td></td>
<td>ng/mL μg/L</td>
</tr>
<tr>
<td>Fibrinogen:</td>
<td></td>
<td></td>
<td>g/L mg/dL</td>
</tr>
<tr>
<td>Globular Filtration Rate:</td>
<td></td>
<td></td>
<td>ml/min</td>
</tr>
<tr>
<td>LDH:</td>
<td></td>
<td></td>
<td>IU/L</td>
</tr>
<tr>
<td>Thyroid peroxidase antibodies:</td>
<td></td>
<td></td>
<td>U/ml</td>
</tr>
<tr>
<td>Troponin:</td>
<td></td>
<td></td>
<td>ng/mL μg/L</td>
</tr>
<tr>
<td>TSH:</td>
<td></td>
<td></td>
<td>mU/L</td>
</tr>
<tr>
<td>Urea (BUN):</td>
<td></td>
<td></td>
<td>g/L mg/dL mmol/L</td>
</tr>
<tr>
<td>Coronavirus antibodies IgA:</td>
<td></td>
<td></td>
<td>Pos Neg</td>
</tr>
<tr>
<td>Coronavirus antibodies IgG:</td>
<td></td>
<td></td>
<td>Pos Neg</td>
</tr>
<tr>
<td>Coronavirus antibodies IgM:</td>
<td></td>
<td></td>
<td>Pos Neg</td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>Test Description</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Was a cardiovascular test done?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, specify type of test and results from list below:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electrocardiogram:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-Minute Walking Distance:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse rate at rest:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other tests performed:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If done: Name of the test _____________________________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Was a pulmonary test done?**                                                   |      |     |         |                   |
| If yes, specify type of test and results from list below:                       |      |     |         |                   |
| Diffusing Capacity for Carbon Monoxide (DCLO) test:                             |      |     |         |                   |
| MRC dyspnoea scale:                                                             |      |     |         |                   |
| Respiratory rate:                                                               |      |     |         |                   |
| Other tests performed:                                                          |      |     |         |                   |
| If done: Name of the test _____________________________________________________ |      |     |         |                   |

| **Was a gastrointestinal test done?**                                           |      |     |         |                   |
| If yes, specify type of test and results below:                                |      |     |         |                   |
| Dysphagia Severity Scale:                                                       |      |     |         |                   |
| Other tests performed:                                                          |      |     |         |                   |
| If done: Name of the test _____________________________________________________ |      |     |         |                   |

| **Was a musculoskeletal test done?**                                            |      |     |         |                   |
| If yes, specify type of test and results from list below:                      |      |     |         |                   |
| Hand grip strength:                                                             |      |     |         |                   |
| MRC Sum Score:                                                                  |      |     |         |                   |
| Timed up and go:                                                                |      |     |         |                   |
| Other tests performed:                                                          |      |     |         |                   |
| If done: Name of the test _____________________________________________________ |      |     |         |                   |

| **Was any test done for fatigue/pain/activities of daily living?**             |      |     |         |                   |
| If yes, specify type of test and results from list below:                      |      |     |         |                   |
| Barthel Index Score:                                                           |      |     |         |                   |
| EQ5D-5L:                                                                       |      |     |         |                   |
| Fatigue Numerical Rating Scale:                                                |      |     |         |                   |
| Fatigue Severity Scale:                                                        |      |     |         |                   |
| Pain Numerical Rating Scale:                                                   |      |     |         |                   |
| Other tests performed:                                                         |      |     |         |                   |
| If done: Name of the test _____________________________________________________ |      |     |         |                   |

| **Other tests performed**                                                      |      |     |         |                   |

| **Results**                                                                 |      |     |         |                   |

*Note: Fill in the blanks with appropriate data.*
### 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 

**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 ________