

## Global COVID-19 Clinical Platform

### Case Report Form (CRF) for Post COVID condition (Post COVID-19 CRF)

The WHO has established a Global Clinical Data Platform<sup>1</sup> 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<sup>1</sup> 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 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).

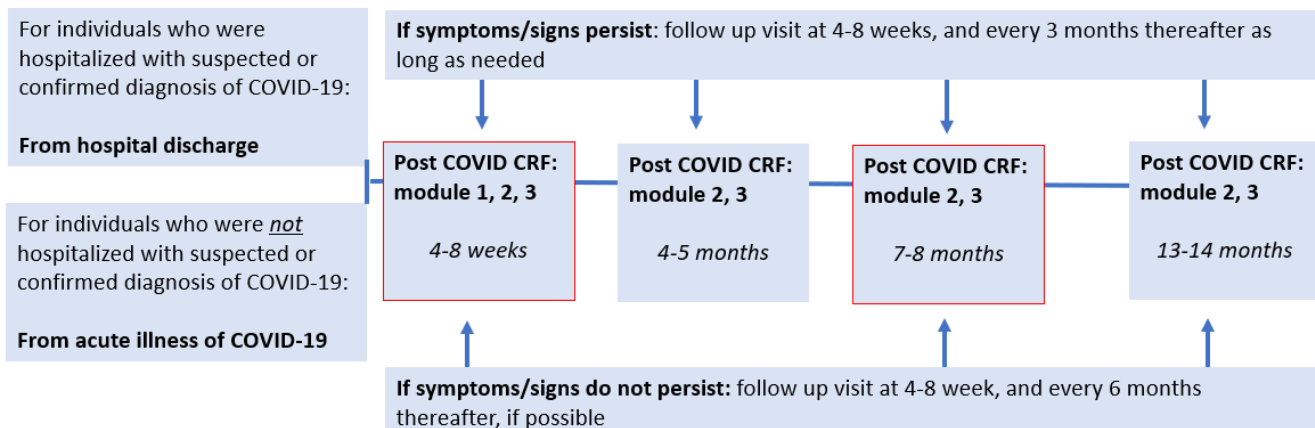
**Mode of administration:**

**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](mailto: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.



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



**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 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
<b>Mild</b>	No hypoxia or pneumonia	Did not receive oxygen
<b>Moderate</b>	Clinical signs of non-severe pneumonia <i>AND</i> SpO <sub>2</sub> > 90% on room air	
<b>Severe</b>	<b>Adults/adolescents:</b> Clinical signs of severe pneumonia <i>AND</i> SpO <sub>2</sub> < 90% on room air; <i>OR</i> RR > 30 breaths/min <b>Children:</b> Clinical signs of severe pneumonia <i>AND at least one of the following:</i> central cyanosis; <i>OR</i> SpO <sub>2</sub> < 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)
<b>Critical</b>	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)

**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: | | | 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 4th 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



## 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:

- 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



### 3.3 Blood tests

Was a blood test done?  Yes  No  Unknown;

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

<b>Albumin:</b>	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> g/L <input type="checkbox"/> g/dL
<b>ALT/SGPT:</b>	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> IU/L
<b>Antithyroglobulin:</b>	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> IU/ml
<b>AST/SGOT:</b>	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> IU/L
<b>Creatine Kinase MM:</b>	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> IU/L <input type="checkbox"/> UKAT/L
<b>Creatinine:</b>	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> mg/dL <input type="checkbox"/> $\mu$ mol/L
<b>C-reactive protein (CRP):</b>	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> mg/L
<b>D-Dimer:</b>	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> ng/mL <input type="checkbox"/> $\mu$ g/L
<b>Fasting Blood Glucose:</b>	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> mg/dL
<b>Ferritin:</b>	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> ng/mL <input type="checkbox"/> $\mu$ g/L
<b>Fibrinogen:</b>	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> g/L <input type="checkbox"/> mg/dL
<b>Globular Filtration Rate:</b>	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> ml/min
<b>LDH:</b>	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> IU/L
<b>Lymphocytes:</b>	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> cells/ $\mu$ L <input type="checkbox"/> cells/mm <sup>3</sup>
<b>Thyroid peroxidase antibodies:</b>	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> U/ml
<b>Troponin:</b>	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> ng/mL <input type="checkbox"/> $\mu$ g/L
<b>TSH:</b>	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> mU/L
<b>Urea (BUN):</b>	<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
<b>Coronavirus antibodies IgA:</b>	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> Pos <input type="checkbox"/> Neg
<b>Coronavirus antibodies IgG:</b>	<input type="checkbox"/> Done <input type="checkbox"/> Not done	Value:	<input type="checkbox"/> Pos <input type="checkbox"/> Neg
<b>Coronavirus antibodies IgM:</b>	<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; **SPO<sub>2</sub>:** [ ][ ] %  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 \_\_\_\_\_