

**DIAMONDS CRF - patients with suspected COVID19****PATIENT DETAILS (this box should NOT be transmitted outside local hospital):**

Surname: Hospital or NHS number:

First name:

Search patient identification log to see if the patient already consented to the study. If yes, use the previously assigned study number and a new episode number

Partial postcode (UK): |_|_|_|_|_|-|_| X X

DIAMONDS CRF – patients with suspected COVID19

1.1 STUDY ID DETAILS (DIS-Centre ID-subject ID-episode; eg DIS-1101-1001-E01)	
Site code (eg 1101): [][][][]	DOB (ddmmyy): [][][][][][]
Study number [][][][]	Male <input type="checkbox"/> Female <input type="checkbox"/>
Episode (eg 01) [][]	Admission height (cm) Weight (kg)
Alternate study number(s)	
Consented to use research samples Yes <input type="checkbox"/> No <input type="checkbox"/> Consented to share samples? Yes <input type="checkbox"/> No <input type="checkbox"/>	

1.2 ADMISSION TIMELINES																													
Date of symptom onset	D	D	M	M	Y	Y																							
Date of fever onset	D	D	M	M	Y	Y																							
Date & time of first presentation to any hospital	D	D	M	M	Y	Y	H	H	M																				
Admitted to ITU?	Yes <input type="checkbox"/> No <input type="checkbox"/>																												
Date & time admitted to ITU	D	D	M	M	Y	Y	H	H	M																				
Date & time of first research bloods	D	D	M	M	Y	Y	H	H	M																				
Consent date	D	D	M	M	Y	Y																							
1.3 PRESENTING FEATURES					1.4 VITAL SIGNS AT TRIAGE																								
<table border="0"> <tr> <td>Y N</td> <td>Y N</td> </tr> <tr> <td>Fever <input type="checkbox"/></td> <td>Rash <input type="checkbox"/></td> </tr> <tr> <td>Respiratory <input type="checkbox"/></td> <td>Sensory <input type="checkbox"/> (e.g. anosmia, ageusia)</td> </tr> <tr> <td>Cardiac <input type="checkbox"/></td> <td>Headache <input type="checkbox"/></td> </tr> <tr> <td>Gastrointestinal <input type="checkbox"/></td> <td>Other Neuro <input type="checkbox"/></td> </tr> <tr> <td>Musculoskeletal <input type="checkbox"/></td> <td>Shock <input type="checkbox"/></td> </tr> <tr> <td>Lymphadenopathy <input type="checkbox"/></td> <td>Conjunctivitis <input type="checkbox"/></td> </tr> <tr> <td>Oedema/Ascites <input type="checkbox"/></td> <td>Mucositis <input type="checkbox"/></td> </tr> <tr> <td>Involvement of extremities <input type="checkbox"/></td> <td>BCG reactivation <input type="checkbox"/></td> </tr> <tr> <td colspan="2">Other.....</td> </tr> </table>					Y N	Y N	Fever <input type="checkbox"/>	Rash <input type="checkbox"/>	Respiratory <input type="checkbox"/>	Sensory <input type="checkbox"/> (e.g. anosmia, ageusia)	Cardiac <input type="checkbox"/>	Headache <input type="checkbox"/>	Gastrointestinal <input type="checkbox"/>	Other Neuro <input type="checkbox"/>	Musculoskeletal <input type="checkbox"/>	Shock <input type="checkbox"/>	Lymphadenopathy <input type="checkbox"/>	Conjunctivitis <input type="checkbox"/>	Oedema/Ascites <input type="checkbox"/>	Mucositis <input type="checkbox"/>	Involvement of extremities <input type="checkbox"/>	BCG reactivation <input type="checkbox"/>	Other.....		Temperature: Heart Rate: Resp Rate: BP (systolic): Oxygen saturation (%): in air <input type="checkbox"/> in O ₂ <input type="checkbox"/> Central cap refill (s): Ill appearance: Y <input type="checkbox"/> N <input type="checkbox"/> AVPU <input type="checkbox"/> , GCS <input type="checkbox"/> , Blantyre <input type="checkbox"/> : Abbrev. Mental Test Score				
Y N	Y N																												
Fever <input type="checkbox"/>	Rash <input type="checkbox"/>																												
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Oedema/Ascites <input type="checkbox"/>	Mucositis <input type="checkbox"/>																												
Involvement of extremities <input type="checkbox"/>	BCG reactivation <input type="checkbox"/>																												
Other.....																													

1.5 COMORBIDITIES (tick all that apply)		Don't Know or Not Stated? <input type="checkbox"/>
Dementia; specify:	<input type="checkbox"/>	Allergic disease; specify:
Endocrine; specify:	<input type="checkbox"/>	Genetic, eg T21; specify:
Smoking; n/day:	<input type="checkbox"/>	Recent surgery; specify:
Malignancy; specify:	<input type="checkbox"/>	Hypertension:
Pulmonary; specify:	<input type="checkbox"/>	Organ transplant; specify:
Gastrointestinal; specify:	<input type="checkbox"/>	Obesity, BMI:
Neurological; specify:	<input type="checkbox"/>	Consanguinity; specify:
Cardiac; specify:	<input type="checkbox"/>	Pregnant; Gestation:/40
Immunosuppressed; e.g HIV, specify:	<input type="checkbox"/>	Clinical Frailty Scale (Dalhousie):/9
Haematology, e.g. HbSS, specify:	<input type="checkbox"/>	Prematurity; Gestation:/40
Important history not captured above – please use ICD10 codes:		

1.6 SELF-REPORTED ETHNICITY (TICK AS APPLICABLE)				
White European	Black	Asian	Middle-Eastern	South American
<input type="checkbox"/> North/Mid/East European	<input type="checkbox"/> North African (Morocco, Algeria, Tunisia, Libya, Egypt)	<input type="checkbox"/> South Asian (Indian, Pakistani, Bangladeshi, Tamil)	<input type="checkbox"/> Turkish	<input type="checkbox"/> Native American
<input type="checkbox"/> South Europe (Mediterranean & Portugal)	<input type="checkbox"/> Sub-Saharan	<input type="checkbox"/> South East Asian (Vietnamese, Cambodian, Thai, Malay, Indonesian, Filipino)	<input type="checkbox"/> Arabian Peninsula	<input type="checkbox"/> Other..... <input type="checkbox"/> Mixed.....
<input type="checkbox"/> Roman	<input type="checkbox"/> Black Caribbean	<input type="checkbox"/> West Asian (Afghan, Iranian)	<input type="checkbox"/> Jewish	
<input type="checkbox"/> Finnish		<input type="checkbox"/> East Asian (Chinese, Japanese, Korean)		

2.1 INVESTIGATIONS, SEVERITY & TREATMENT

	Default	Units if different	Baseline (if not with 1 st research bloods)	1 st research bloods/on admission	2 nd research bloods	3 rd research bloods (at 28 days/convalesce)
DATE:	dd/mm/yy					
TIME:	hh:mm					
Haematology						
Haemoglobin	g/L					
White cells	10 ⁹ /L					
Platelets	10 ⁹ /L					
Neutrophils	10 ⁹ /L					
Lymphocytes	10 ⁹ /L					
Monocytes	10 ⁹ /L					
Eosinophils	10 ⁹ /L					
Fibrinogen	g/L					
D-dimer	ng/ml					
PT	seconds					
Chemistry						
Urea	mmol/L					
Creatinine	micromol/L					
ALT	IU/L					
Bilirubin	micromol/L					
Albumin	g/L					
CRP	mg/L					
PCT	ng/ml					
Ferritin	ug/L					
Trop-T	ng/L					
BNP / NT-proBNP	pg/ml					
LDH	IU/L					
CK	IU/L					
sCD-25						
Blood gas:						
Base excess	mmol/L					
Lactate	mmol/L					
pO ₂	kPa					
Severity						
Patient location		ED <input type="checkbox"/> Ward <input type="checkbox"/>	HDU <input type="checkbox"/> ICU <input type="checkbox"/>	ED <input type="checkbox"/> Ward <input type="checkbox"/>	HDU <input type="checkbox"/> ICU <input type="checkbox"/>	ED <input type="checkbox"/> Ward <input type="checkbox"/> ICU <input type="checkbox"/>
Ventilation		Invasive <input type="checkbox"/> O2 only <input type="checkbox"/>	NIV <input type="checkbox"/> None <input type="checkbox"/>	Invasive <input type="checkbox"/> O2 only <input type="checkbox"/>	NIV <input type="checkbox"/> None <input type="checkbox"/>	Invasive <input type="checkbox"/> O2 only <input type="checkbox"/> NIV <input type="checkbox"/> None <input type="checkbox"/>
O ₂ Saturation	%					
FiO ₂ / O ₂ Flow	% or L/min		% <input type="checkbox"/> L / min <input type="checkbox"/>	% <input type="checkbox"/> L / min <input type="checkbox"/>	% <input type="checkbox"/> L / min <input type="checkbox"/>	% <input type="checkbox"/> L / min <input type="checkbox"/>
Heart rate	/min					
Systolic BP	mmHg					
Respiratory rate	/min					
Capillary refill	s					
GCS/AVPU	/15; AVPU					
Inotropes		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
ECMO		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Haemofiltration		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Treatment:	Name(s):	Please Tick YES if patient has received treatment since last bloods (or prior to bloods for baseline)				
Antibiotic		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Antiviral		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Antimalarial		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Steroid > 1mg/kg		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Immunoglobulin		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Monoclonal Ab		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Study Treatment	Study Name:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Maximum CRP (mg/L):		Max neutrophil count(10⁹/L):		Min lymphocyte count(10⁹/L):		

3.1 RADIOLOGY RESULTS		Yes	No	Yes	No
Chest X-ray:	Had CXR?	<input type="checkbox"/>	<input type="checkbox"/>		
	Normal	<input type="checkbox"/>	<input type="checkbox"/>		
	Infiltrates	<input type="checkbox"/>	<input type="checkbox"/>		
	Pneumonia with consolidation	<input type="checkbox"/>	<input type="checkbox"/>		
	Pleural effusions	<input type="checkbox"/>	<input type="checkbox"/>		
	Pulmonary emboli	<input type="checkbox"/>	<input type="checkbox"/>		
	X-ray: Other:			
	CT: interstitial disease	<input type="checkbox"/>	<input type="checkbox"/>		
	CT: Other			
	MRI:			
	Other			

3.2 CARDIAC INVESTIGATIONS		1st ECHO; Date			Worst ECHO; Date		
Coronary arteries	Normal	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unk <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unk <input type="checkbox"/>
For largest two CAs	Location						
Left coronary: LCA; Circumflex:	Lopez Z-score						
Cx; Left anterior descending:	Internal diameter mm						
LAD; Right Coronary: RCA							
Overall Function	Myocarditis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unk <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unk <input type="checkbox"/>
	Low Cardiac Output Syndrome	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unk <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unk <input type="checkbox"/>
	Pericarditis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unk <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unk <input type="checkbox"/>
	Valvular regurgitation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unk <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unk <input type="checkbox"/>
	Fractional Shortening (%)						
	LV end-diastolic diameter						
	ECG	Normal <input type="checkbox"/> Block <input type="checkbox"/>			Normal <input type="checkbox"/> Block <input type="checkbox"/>		
		Arrhythmia <input type="checkbox"/> Other <input type="checkbox"/>			Arrhythmia <input type="checkbox"/> Other <input type="checkbox"/>		

4.1 VIROLOGY & BACTERIOLOGY

Test	Date(s) (ddmmyy)	Results	
SARS-CoV-2	<input type="checkbox"/>	PCR <input type="checkbox"/> Ct value...../VL..... Test 1: Test2:	Ag <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> All negative <input type="checkbox"/> Subsequent Test(s):
Blood culture	<input type="checkbox"/>	Central line <input type="checkbox"/> Peripheral <input type="checkbox"/>	All negative <input type="checkbox"/>
Blood PCR, rapid antigen (bacteriology)	<input type="checkbox"/>	RAg <input type="checkbox"/> PCR <input type="checkbox"/>	All negative <input type="checkbox"/>
Blood PCR (virology)	<input type="checkbox"/>	PCR <input type="checkbox"/>	Negative <input type="checkbox"/>
CSF metrics	<input type="checkbox"/>	White cells Neutrophils %/abs Lymphocytes %/abs Protein CSF & blood Glucose CSF lactate	
CSF bacterial	<input type="checkbox"/>	Culture <input type="checkbox"/> RAg/IF <input type="checkbox"/> PCR <input type="checkbox"/>	All negative <input type="checkbox"/>
CSF virology	<input type="checkbox"/>	PCR <input type="checkbox"/>	Negative <input type="checkbox"/>
Urinalysis	<input type="checkbox"/>	Dipstix (nitrites, leukocytes, protein)	Microscopy (epithelial & white cells)
Urine organism	<input type="checkbox"/>	Culture <input type="checkbox"/> RAg <input type="checkbox"/> PCR <input type="checkbox"/>	All negative <input type="checkbox"/>
Nose, throat swab	<input type="checkbox"/>	Culture <input type="checkbox"/> RAg/IF <input type="checkbox"/> PCR <input type="checkbox"/>	All negative <input type="checkbox"/>
Nasopharyngeal aspirate	<input type="checkbox"/>	Culture <input type="checkbox"/> RAg/IF <input type="checkbox"/> PCR <input type="checkbox"/>	All negative <input type="checkbox"/>
Stool bacteriology	<input type="checkbox"/>	Culture <input type="checkbox"/> RAg/IF <input type="checkbox"/> PCR <input type="checkbox"/>	All negative <input type="checkbox"/>
Stool virology	<input type="checkbox"/>	RAg/IF <input type="checkbox"/> PCR <input type="checkbox"/>	All negative <input type="checkbox"/>
BAL	<input type="checkbox"/>		Negative <input type="checkbox"/>
ETT Aspirate	<input type="checkbox"/>		Negative <input type="checkbox"/>
Serology results	<input type="checkbox"/>		Negative <input type="checkbox"/>
Other test			

5.1 – 5.3 CAUSATIVE ORGANISM(S) IN THIS ILLNESS – tick those that apply

Identify pathogens from results & clinical findings (eg positive swab result, or pathognomonic varicella rash)

Evidence of viral aetiology	yes no	Evidence of bacterial cause	yes no	Non-bacterial/viral?	yes no
Specify virus(es)	<input type="checkbox"/> <input type="checkbox"/>	Specify bacteria.....	<input type="checkbox"/> <input type="checkbox"/>	Specify pathogen.....	<input type="checkbox"/> <input type="checkbox"/>
Virus consistent with some but NOT all symptoms?	<input type="checkbox"/> <input type="checkbox"/>	Bacteria consistent with some but NOT all symptoms?	<input type="checkbox"/> <input type="checkbox"/>	Pathogen consistent with some but NOT all symptom	<input type="checkbox"/> <input type="checkbox"/>
Virus likely to account for all features of the illness?	<input type="checkbox"/> <input type="checkbox"/>	Bacteria likely to account for all features of the illness?	<input type="checkbox"/> <input type="checkbox"/>	Pathogen likely accounts for all features of illness?	<input type="checkbox"/> <input type="checkbox"/>

6.1 DISCHARGE DESTINATION & TIMELINES		Reason for transfer:.....	
Discharged home from ED	Y <input type="checkbox"/> N <input type="checkbox"/>	Admitted to ICU from ED	Y <input type="checkbox"/> N <input type="checkbox"/>
Admitted to ward from ED	Y <input type="checkbox"/> N <input type="checkbox"/>	Died in ED	Y <input type="checkbox"/> N <input type="checkbox"/>
Transferred out from ED	Y <input type="checkbox"/> N <input type="checkbox"/>	Date/Time left ED:	D D M M Y Y H H M M
Date/time of ICU discharge	Date:	D D M M Y Y H H M M	
Date/time of discharge from hospital	Date:	D D M M Y Y H H M M	
Date/time of death, if died	Date:	D D M M Y Y H H M M	
If died, was SARS-CoV-2:	likely cause of death <input type="checkbox"/>	contributed to death <input type="checkbox"/>	incidental to death <input type="checkbox"/>

6.2 CEILING OF CARE (if admitted)	6.3 SEVERITY (Note: Days = number of midnights on intervention + 1)
Ward only <input type="checkbox"/>	yes no
NIV on ward <input type="checkbox"/>	Oxygen <input type="checkbox"/> <input type="checkbox"/> Days ...
ITU care <input type="checkbox"/>	NIV <input type="checkbox"/> <input type="checkbox"/> Days ...
No Ceiling of Care <input type="checkbox"/>	Invasive Vent <input type="checkbox"/> <input type="checkbox"/> Days ...
Unknown <input type="checkbox"/>	ICU <input type="checkbox"/> <input type="checkbox"/> Days ...
DNACPR? Y <input type="checkbox"/> N <input type="checkbox"/> Unk <input type="checkbox"/>	yes no
	Inotropes <input type="checkbox"/> <input type="checkbox"/> Days ...
	ECMO <input type="checkbox"/> <input type="checkbox"/> Days ...
	Haemofiltration <input type="checkbox"/> <input type="checkbox"/> Days ...
	Patient died <input type="checkbox"/> <input type="checkbox"/>

7.1 SYNDROME CLASSIFICATION – tick main syndrome (tick more than one if required)			
Cardiovascular	Arrhythmia <input type="checkbox"/>	Cardiac Arrest <input type="checkbox"/>	Cardiac Ischaemia <input type="checkbox"/>
	Congestive Heart Failure <input type="checkbox"/>	Central Artery Vasculitis <input type="checkbox"/>	Endocarditis <input type="checkbox"/>
	Myocarditis <input type="checkbox"/>	Pericarditis <input type="checkbox"/>	Peripheral Artery Vasculitis <input type="checkbox"/>
GIT	Mod/severe diarrhoea <input type="checkbox"/>	Mod/severe vomiting <input type="checkbox"/>	
Haematological	Deep Vein Thrombosis <input type="checkbox"/>	Pulmonary Embolism <input type="checkbox"/>	Sickle Crisis <input type="checkbox"/>
Inflammatory	SLE <input type="checkbox"/>	Kawasaki Disease <input type="checkbox"/>	Macrophage Activation Synd. <input type="checkbox"/>
	Juvenile Idiopathic Arthritis <input type="checkbox"/>	COVID-related inflammation <input type="checkbox"/>	Steven-Johnson Synd. <input type="checkbox"/>
Lower respiratory tract	Asthma Exacerbation <input type="checkbox"/>	Bronchiolitis <input type="checkbox"/>	Empyema <input type="checkbox"/>
	Pleural Effusion <input type="checkbox"/>	Pneumonia <input type="checkbox"/>	Pneumothorax <input type="checkbox"/>
	Undefined LRTI <input type="checkbox"/>	Viral Induced Wheeze <input type="checkbox"/>	
Musculoskeletal	Arthralgia <input type="checkbox"/>	Discitis <input type="checkbox"/>	Myositis <input type="checkbox"/>
	Osteomyelitis <input type="checkbox"/>	Reactive arthritis <input type="checkbox"/>	Septic arthritis <input type="checkbox"/>
	Transient synovitis <input type="checkbox"/>		
Neurological	CNS Abscess <input type="checkbox"/>	Encephalitis <input type="checkbox"/>	Meningitis <input type="checkbox"/>
	Seizure <input type="checkbox"/>	Stroke / CVA <input type="checkbox"/>	
Pathogen syndromes	COVID19 <input type="checkbox"/>	EBV/Glandular fever <input type="checkbox"/>	Flu-like illness <input type="checkbox"/>
	Hand-foot-mouth <input type="checkbox"/>	Hepatitis A <input type="checkbox"/>	HSV stomatitis <input type="checkbox"/>
	Lyme disease <input type="checkbox"/>	Malaria <input type="checkbox"/>	Measles <input type="checkbox"/>
	Mumps <input type="checkbox"/>	Pertussis <input type="checkbox"/>	Roseola/HHV6 <input type="checkbox"/>
	Scarlet fever <input type="checkbox"/>	Staph scalded skin <input type="checkbox"/>	Varicella <input type="checkbox"/>
Sepsis syndromes	Bacteraemia <input type="checkbox"/>	Febrile neutropaenia <input type="checkbox"/>	Purpura fulminans <input type="checkbox"/>
	Septic shock <input type="checkbox"/>	Severe sepsis <input type="checkbox"/>	Toxic shock syndrome <input type="checkbox"/>
Soft tissue	Abscess <input type="checkbox"/>	Cellulitis (skin) <input type="checkbox"/>	Impetigo <input type="checkbox"/>
	Infected eczema <input type="checkbox"/>	Lymphadenitis <input type="checkbox"/>	Necrotising fasciitis <input type="checkbox"/>
	Peri/orbital cellulitis <input type="checkbox"/>	Wound infection <input type="checkbox"/>	
Surgical	Appendicitis <input type="checkbox"/>	Bowel obstruction <input type="checkbox"/>	Mesenteric adenitis <input type="checkbox"/>
	Pancreatitis <input type="checkbox"/>	Peritonitis <input type="checkbox"/>	
Undifferentiated fever	Febrile convulsion <input type="checkbox"/>	Fever without source <input type="checkbox"/>	Fever unknown origin <input type="checkbox"/>
	Post procedural fever <input type="checkbox"/>		
Urinary tract	Haemolytic uremic syndrome <input type="checkbox"/>	Pyelonephritis <input type="checkbox"/>	UTI <input type="checkbox"/>
URTI/Ear nose throat	Abscess <input type="checkbox"/>	Croup <input type="checkbox"/>	Mastoiditis <input type="checkbox"/>
	Otitis media <input type="checkbox"/>	Pharyngitis <input type="checkbox"/>	Sinusitis <input type="checkbox"/>
	Stomatitis/lip infection <input type="checkbox"/>	Tonsillitis <input type="checkbox"/>	URTI (non-specific) <input type="checkbox"/>
Other infections	CLABSI (line infection) <input type="checkbox"/>	Conjunctivitis <input type="checkbox"/>	
Details of above syndromes (eg location, sub-type)		Other syndrome, give ICD10 code:	

8.1 PRIMARY PHENOTYPE– tick ONE box (see diagram below), prioritising the bacterial/viral (coloured) boxes

Definite bacterial infection	yes <input type="checkbox"/>	Viral syndrome - high or no inflammatory markers	yes <input type="checkbox"/>	Other infection including parasites	yes <input type="checkbox"/>
Probable bacterial infection	<input type="checkbox"/>	Probable viral infection	<input type="checkbox"/>	Uncertain – infection or inflammatory syndrome	<input type="checkbox"/>
Bacterial syndrome - low or no inflammatory markers	<input type="checkbox"/>	Definite viral infection	<input type="checkbox"/>	Inflammatory syndrome – confident diagnosis	<input type="checkbox"/>
Unknown bacterial or viral infection	<input type="checkbox"/>	Trivial illness: no investigations, treatment, or follow-up	<input type="checkbox"/>	Other cause of illness – specify:	<input type="checkbox"/>

8.2 SECONDARY PHENOTYPE – use only if a co-incident, confirmed non-bacterial non-viral illness is ALSO responsible for some or all features of the illness (eg malaria, inflammatory condition, chronic infection)

Other Infection	yes <input type="checkbox"/>	Inflammatory	yes <input type="checkbox"/>
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Initials concurring with final phenotype:

Initials not concurring with final phenotype:

Lopez Z-scores for coronary arteries: <http://www.parameterz.com/sites/coronary-arteries>

To view the phenotyping algorithm, please use this link:

<https://imperialcollegelondon.box.com/s/uemqmuzv7vms3ws7c856797ik4cnhhq1>Click [here for the Dalhousie Clinical Frailty Scale](#)

SAMPLE HANDLING RECORD**STUDY ID DETAILS** (DIS-Centre ID-subject ID-episode; e.g. DIS-1101-1001-E01)
 DIS-..... Alternative Study number.....
 Centre ID Subject ID Episode

Sample type	Collected Yes No	Date and time of sample collection			Time to processing (initial storage)	Sample aliquots: volume and number (if applicable)	Storage location
		Time Point (1st,2nd,Dis)	Date	Time			
Example: Blood EDTA	<input checked="" type="checkbox"/> <input type="checkbox"/>	1 st	22-01-2012	23:45	6h (in fridge)	Plasma (100µl): 5 Plasma (250µl): 1 EDTA aliquot (Volume): 1 x 450µl Cell Pellet (all) (µl): 4 Smart tube (200µl):	Imp Coll, -80°C freezer 9, box 6
Blood EDTA	<input type="checkbox"/> <input type="checkbox"/>	Tick if same draw as blood culture <input type="checkbox"/>				Plasma (100µl): Plasma (250µl): EDTA aliquot (Volume): Cell Pellet (all) (µl): Smart tube (200µl):	
	<input type="checkbox"/> <input type="checkbox"/>					Plasma (100µl): Plasma (250µl): EDTA aliquot (Volume): Cell Pellet (all) (µl): Smart tube (200µl):	
	<input type="checkbox"/> <input type="checkbox"/>					Plasma (100µl): Plasma (250µl): EDTA aliquot (Volume): Cell Pellet (all) (µl):	
RNA: PAXgene <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>					Whole tube <input type="checkbox"/> 'Home-made' <input type="checkbox"/>	
TEMPUS <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>					Whole tube <input type="checkbox"/> 'Home-made' <input type="checkbox"/>	
Serum	<input type="checkbox"/> <input type="checkbox"/>					Serum (100µl): Serum (250µl): Serum (100µl): Serum (250µl): Serum (100µl): Serum (250µl):	
Throat swab	<input type="checkbox"/> <input type="checkbox"/>						
Stool/rectal swab	<input type="checkbox"/> <input type="checkbox"/>						
BAL sample	<input type="checkbox"/> <input type="checkbox"/>						
Other:							
Other:							

Sample handling deviations

	If any answer is NO (& for any other deviation) please comment over page	TP1	TP2	DIS
BLOOD EDTA	If the sample was not processed immediately, was it stored at 4°C within 2 hours?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
	Was the sample processed according to SOP and stored at -80°C within 6 hours?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
BLOOD SERUM	Was the sample processed according to SOP and stored at -80°C within 24 hours?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
SMART tube	Was the sample processed according to SOP and stored at -80°C within 15 minutes?	Y <input type="checkbox"/> N <input type="checkbox"/>	n/a	n/a
	If the sample was not stored at -80°C within 15 minutes, was it kept at 4°C for 1 hour before being stored at -80°C?	Y <input type="checkbox"/> N <input type="checkbox"/>	n/a	n/a
PAX tube	Was the sample stored for a minimum of 24 hours at -20°C, before storage at -80°C?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Throat swab	Was the sample stored at -80°C within 4 weeks?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>

Comments/details Please give details stating clearly which sample type and what time point was affected.