CONTROL COVID

CONTROL OF COVID-19 OUTBREAKS IN LONG TERM CARE

Today's Date_____

Resident ID: ___ ___ ___ R ___ ___ ___ Day 14 Assessment Date_____

DAY 40 DATA EXTRACTION FOR RESIDENTS

Research staff name: _____ Date of last chart review_____

dd/mm/yy

1. Have any of the following symptoms been recorded since the last assessment? (check all that apply)

Line-List	**Chart Review** Consistent with line-list: ☐ Yes ☐ No *If no, record answer to question 1, as per chart review:*	**Resolution** *If discrepancy between line-list and chart review, record the resolved answer to question 1:*
☐Fever (≥37.8ºC), record temperature:__ __.___ ºC ☐ Did not take temperature ☐Cough ☐Fatigue ☐Sore muscles ☐Sore joints ☐Shortness of breath ☐Sore throat ☐Chills ☐ Loss of appetite ☐ Vomiting ☐ Diarrhea ☐ Change in level of responsiveness ☐ Change in level of function (ability to do day-to-day activities) (*If yes to at least one symptom*), On what day, was the first symptom recorded (dd/mm/yyyy)? ___/____/_____	☐Fever (≥37.8ºC), record temperature:__ __.___ ºC ☐ Did not take temperature ☐Cough ☐Fatigue ☐Sore muscles ☐Sore joints ☐Shortness of breath ☐Sore throat ☐Chills ☐ Loss of appetite ☐ Vomiting ☐ Diarrhea ☐ Change in level of responsiveness ☐ Change in level of function (ability to do day-to-day activities) (*If yes to at least one symptom*), On what day, was the first symptom recorded (dd/mm/yyyy)? ___/____/_____	☐Fever (≥37.8ºC), record temperature:__ __.___ ºC ☐ Did not take temperature ☐Cough ☐Fatigue ☐Sore muscles ☐Sore joints ☐Shortness of breath ☐Sore throat ☐Chills ☐ Loss of appetite ☐ Vomiting ☐ Diarrhea ☐ Change in level of responsiveness ☐ Change in level of function (ability to do day-to-day activities) (*If yes to at least one symptom*), On what day, was the first symptom recorded (dd/mm/yyyy)? ___/____/_____

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2. Was the resident tested for COVID-19 since the last assessment?

Line-List	**Chart Review** Consistent with line-list: ☐ Yes ☐ No *If no, record answer to question 2. as per chart review:*	**Resolution** *If discrepancy between line-list and chart review, record the resolved answer to question 2:*
☐Yes ☐No *If yes*, specify date of test (dd/mm/yyyy): ____ / ____ /_____ Specify result (positive or negative):_____ Specify reason for test:_____	☐Yes ☐No *If yes*, specify date of test (dd/mm/yyyy): ____ / ____ /_____ Specify result (positive or negative):_____ Specify reason for test:_____	☐Yes ☐No *If yes*, specify date of test (dd/mm/yyyy): ____ / ____ /_____ Specify result (positive or negative):_____ Specify reason for test:_____

3. Please list all new medications (apart from study drug) taken since the last assessment:

_____

_____

4. As per the medication administration record, has the resident taken the study drug every day? (4 pills twice per day*)
   * if patient is receiving treatment doses then 5 pills twice per day

☐Yes

☐No, the resident has missed at least one dose of study drug

If no, how many doses were missed in total since the last assessment?__ __

And on how many days total were doses missed?__ __

Why were the dose(s) missed?

- ☐ Adverse event, Form number: _____
- ☐ Decision to withdraw from meds
- ☐ Refusal to take
- ☐ Other, specify: _____

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5. Have any adverse events been recorded since the last assessment?

Line-List	**Chart Review** Consistent with line-list: ☐ Yes ☐ No *If no, record answer to question 5, as per chart review:*	**Resolution** *If discrepancy between line-list and chart review, record the resolved answer to question 5:*
☐Yes ☐No *If yes,* please describe:_____	☐Yes ☐No *If yes,* please describe:_____	☐Yes ☐No *If yes,* please describe:_____

(*For adverse events, fill out adverse event form and indicate form number:_____)*

6. Has the resident been assessed by the LTCH physician since the last assessment?
   ☐Yes ☐No
   If yes, specify date of assessment (dd/mm/yyyy): ____ / ____ /____
   Specify reason/outcome of assessment:_____
   (*If this is an adverse event, fill out adverse event form and indicate form number:_____)*

7. Has the resident undergone bloodwork at the LTCH since the last assessment?
   ☐Yes ☐No
   If yes, specify date of bloodwork (dd/mm/yyyy): ____ / ____ /_____
   Specify reason:_____
   Specify test (and result):_____
   (*If this is an adverse event, fill out adverse event form and indicate form number:_____)*

8. Has the resident developed any other new medical problems since the last assessment?
   ☐Yes ☐No
   If yes, specify date of identification (dd/mm/yyyy): ____ / ____ /_____
   Specify medical problem:_____
   (*If this is an adverse event, fill out adverse event form and indicate form number:_____)*

9. Has the resident been transferred to acute care facility/hospital since the last assessment?

Line-List	**Chart Review** Consistent with line-list: ☐ Yes ☐ No	**Resolution** *If discrepancy between line-list and chart review, record the resolved answer to question 9:*

Today's Date_____

Resident ID: ___ ___ ___ R ___ ___ ___ Day 14 Assessment Date_____

	If no, record answer to question 9, as per chart review:	
☐Yes ☐No *If yes*, specify date of transfer (dd/mm/yyyy): ____ / ____ /_____ Specify reason for transfer:_____	☐Yes ☐No *If yes*, specify date of transfer (dd/mm/yyyy): ____ / ____ / ____ Specify reason for transfer:_____	☐Yes ☐No *If yes*, specify date of transfer (dd/mm/yyyy): ____ / ____ /____ Specify reason for transfer:_____

(*If this is an adverse event, fill out adverse event form and indicate form number:_____)*

10. Has the resident died?

Line-List	**Chart Review** Consistent with line-list: ☐ Yes ☐ No *If no, record answer to question 10, as per chart review:*	**Resolution** *If discrepancy between line-list and chart review, record the resolved answer to question 10:*
☐Yes ☐No *If yes*, specify date of death (dd/mm/yyyy): ____ / ____ /_____ Specify cause of death: _____	☐Yes ☐No *If yes*, specify date of death (dd/mm/yyyy): ____ / ____ /____ Specify cause of death: _____	☐Yes ☐No *If yes*, specify date of death (dd/mm/yyyy): ____ / ____ /____ Specify cause of death: _____

(*If this is an adverse event, fill out adverse event form with participant and indicate form number:_____)*

11. If patient died, did they have a swab (pre-mortem or post-mortem)? ☐Yes ☐No

If yes, date of swab: _____(dd/mm/yyyy)