Complete at patient’s discharge, transfer or death

### Section A: Complications

<table>
<thead>
<tr>
<th></th>
<th>Date of discharge (dd/mmm/yyyy)</th>
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</thead>
<tbody>
<tr>
<td>1. dischargedate</td>
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</tbody>
</table>

#### 2. anycomplic

At any time during hospitalization did the patient experience any of the following complications?

- Pneumonia
- Pneumothorax
- Pleural effusion
- Cryptogenic organizing pneumonia (COP)
- Bronchiolitis
- Meningitis / Encephalitis
- Seizure
- Stroke / Cerebrovascular accident
- Congestive heart failure
- Endocarditis / Myocarditis / Pericarditis
- Cardiac ischaemia
- Cardiac arrhythmia
- Cardiac arrest
- Bacteremia
- Coagulation disorder / Disseminated
- Intravascular Coagulation
- Anemia
- Rhabdomyolysis / Myositis
- Acute renal injury/ Acute renal failure
- Gastrointestinal haemorrhage
- Pancreatitis
- Liver dysfunction
- Hyperglycemia
- Hypoglycemia
- Other

#### 3. labtests

Was there other pathogens tested for during admission?

- Yes | No | UNK | If yes complete below:

  - Influenza: YES | NO | UNK |
  - SARS-COV2: YES | NO | UNK |
  - Bacteria: YES | NO | UNK | if Yes, specify__________________________
  - Other Infectious Respiratory diagnosis: YES | NO | UNK |
  - (laboratory confirmed)

If yes Other Infectious Respiratory diagnosis, specify:__________________________

Clinical pneumonia: Yes | No | UNK |

If NONE OF THE ABOVE: Suspected Non-infective: Yes | UNK |
**COVID19 DISCHARGE FORM**

To be completed for every patient with confirmed COVID-19 at discharge, transfer or death. Use the Case Notification Number (CNN) generated at notification as patient ID

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surname</td>
<td>DOB</td>
</tr>
<tr>
<td>CNN</td>
<td>____</td>
</tr>
</tbody>
</table>

**4. Treatment**

At ANY time during hospitalisation, did the patient receive/undergo?

- ICU or High Dependency Unit admission?  
  Yes ___ | No ___ | N/A ___

  If yes,  
  Date of ICU admission: __/__/____ | __/__/____ | __/__/____ | N/A |
  Date of ICU discharge: __/__/____ | __/__/____ | __/__/____ | N/A |

- Oxygen therapy?  
  Yes ___ | No ___ | UNK ___

- Non-invasive ventilation? (e.g. BIPAP, CPAP)  
  Yes ___ | No ___ | UNK ___

  If YES, total duration: _______ days

- Prone Ventilation?  
  Yes ___ | No ___ | UNK ___

- Tracheostomy inserted  
  Yes ___ | No ___ | UNK ___

- Extracorporeal support?  
  Yes ___ | No ___ | UNK ___

- Renal replacement therapy (RRT) or dialysis?  
  Yes ___ | No ___ | UNK ___

- Inotropes/vasopressors?  
  Yes ___ | No ___ | UNK ___

  If YES:  
  First/Start date: __/__/____ | __/__/____ | __/__/____ | UNK |
  Last/End date: __/__/____ | __/__/____ | __/__/____ | UNK |

**5. Medication**

While hospitalised or at discharge, were any of the following administered?

- Antiviral agent?  
  Yes ___ | No ___ | UNK ___

  If YES:  
  Ribavirin  
  Yes ___ | No ___ | UNK ___
  Lopinavir/Ritonavir  
  Yes ___ | No ___ | UNK ___
  Interferon alpha  
  Yes ___ | No ___ | UNK ___
  Interferon beta  
  Yes ___ | No ___ | UNK ___
  Neuraminidase inhibitor (oseltamivir)  
  Yes ___ | No ___ | UNK ___

- Other ____________________________________________

- Antibiotics?  
  Yes ___ | No ___ | UNK ___

  If yes, specify which antibiotic__________________________________________________________

- Route:  
  Oral ___ | Intravenous ___ | Inhaled ___

- Antifungal agent?  
  Yes ___ | No ___ | UNK ___
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If yes, specify which antifungals: ____________________________

Route:  Oral | Intravenous | Inhaled

**Corticosteroids?**  Yes | No | UNK

If yes, specify which corticosteroids: ____________________________

Route:  Oral | Intravenous | Inhaled

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**Section B: Patient Outcomes**

6. **outcomes**

**What is the patient's outcome:**

- Discharged alive | Transfer to step down facility | Died
- Palliative discharge | Unknown

Outcome date: | | | | | | | | | | UNK

**If Discharged alive: Ability to self-care at discharge versus before illness:**

- Same as before illness
- Worse
- Better

**If Discharged alive: Post-discharge treatment:**

- Oxygen therapy?  Yes | No | UNK
- Dialysis/renal treatment?  Yes | No | UNK
- Other intervention or procedure?  Yes | No | UNK

If YES: Specify (multiple permitted):

_______________________________________________________

**If Transferred: Facility name:**

_______________________________________________________

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Republic of South Africa, National Institute for Communicable Diseases; COVID 2019, Discharge Form v1.0; 13th February 2020