



CASE REPORT FORM (CRF)

English version 03

OUTPATIENT EVALUATION

VERSION 18 JANVIER 2021

CÉR Évaluateur (MP-02-2020-8929)

Centre de Recherche du Centre Hospitalier de l'Université de Montréal

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EVALUATION VISIT

Consent

SECTION 1: Consent

Was verbal consent obtained? (by the patient, legal representative or guardian)

☐ Yes ☐ No

Date (yyyy-mm-dd) _____ Time (hh:mm) _____

Obtained by (first name, last name) (CRF paper only): _____

Is the patient able to provide consent?

☐ Yes, go to section 3 ☐ No (adult or minor), go to section 2.

Was the patient recruited with deferred consent?

☐ Yes ☐ No

SECTION 2: Incapacitated patient – Legal representative

If NO (INAPTITUDE OR PATIENT AGE <18 YEARS) has verbal consent been given by the legal representative with the authority to consent?

- ☐ No
☐ Legal representative (adult)
☐ Legal representative / guardian (child under 18 years of age)

Has the adult participant regained capacity to consent?

☐ Yes ☐ No

Date of verbal consent of adult participant became capable (yyyy-mm-dd): _____

The patient's assent (if 14 years of age or older) has been obtained (pediatric component, if applicable)?

☐ Yes ☐ No

Relationship of the representative with the patient: : _____

SECTION 3: IFC follow up sent (mail and/or email)

The consent form has been given/sent to the patient or their representative?

☐ Yes ☐ No

Who was the ICF sent to?

- ☐ Participant
☐ Legal representative (participant who has remained incapacitated or deceased)
☐ Legal representative / guardian (child under 18 years of age)

Date it was sent/delivered (mail or email) (yyyy-mm-dd)? _____

Has signed consent form been received?

☐ Yes (go to section 4) ☐ No (continue to complete the section 3)

Date of receipt (mail or email) (yyyy-mm-dd)? _____

ICF received was signed by?

- ☐ Participant
☐ Legal representative (participant who has remained incapacitated or deceased)
☐ Legal representative / guardian (child under 14 years of age)
☐ Legal representative / guardian AND child between 14 and 18 years of age

If signed form not received, patient or legal representative has been contacted again?
☐ Yes ☐ No

Date (yyyy-mm-dd) _____ Time (hh:mm) (CRF paper only.) : _____ ☐ Inconclusive
 Date (yyyy-mm-dd) _____ Time (hh:mm) (CRF paper only.) : _____ ☐ Inconclusive
 Date (yyyy-mm-dd) _____ Time (hh:mm) (CRF paper only.) : _____ ☐ Inconclusive

SECTION 4: Response to the return of the ICF
Conclusion of consent approach:

- ☐ Patient unreachable or deceased
☐ Patient wishes to withdraw from the study
☐ Consent to blood draws only
☐ Consent to follow-up only
☐ Consent to all study procedures

Patient requests withdrawal of consent to participate in the BQC19 study (at any time during the project).

☐ Yes ☐ No

Date of withdrawal of consent (yyyy-mm-dd): _____

Comments : _____

SECTION 5: Database Authorizations

[Check all of the following options]

Authorized research ☐ Genetic ☐ Health research
 Link with administrative database ☐ RAMQ ☐ MSSS ☐ LSPQ
 Authorized for ☐ Academic researchers ☐ Industry researchers

Other studies in which the patient participates (other than the BQC study):

Project title *	Study participant ID/randomisation ID (if available)

* **1**, CONCOR-1 (plasma convalescent); **2**, HALO; **3**, LOVIT; **4**, COVID-19 PEP RCT; **5**, COLCORONA; **6**, CATCO; **7**, REMAP-CAP; **8**, ATTACC; **9**, COVACTA; **10**, CODA19; **11**, COFA-025; **12**, COFA-004; **13**, COFA-023; **14**, REMAP-CAP; **15**, U-EFC16844; **16**, REVISE; **17**, 10-256 Biorepository; **18**, Neuropathologie de la perte olfactive liée au SARS-CoV2 dans une cohorte des travailleurs de la santé; **19**, COVID QT; **20**, ELCV

Identifiers - confidential

*[*These identifiers are entered ONLY in the local BTRSR database. ** These identifiers are entered into the REDCap CRF]*

BTRSR ID (BTRSR participant number)* :

Other participant code * :

First name* :

Last name* :

Date of Birth*,** (yyyy-mm-dd) :

The date of birth must be re-entered in the profile section of the REDCap CRF.

Participant Address :

Street (CRF paper only.):

City (CRF paper only.):

Province (CRF paper only.):

Postal Code* :

#RAMQ* :

Medical Record Number* :

Primary Phone Number :

Secondary Phone Number :

Participant E-mail** :

Surrogate Name and Relationship to Patient :

Surrogate Phone Number :

Surrogate E-mail Address :

Participant Profile

Has the participant been hospitalized or is the participant seen on an outpatient?

☐ Hospitalized
☐ Outpatient

Age at the time of arrival :

**Calculates automatically with the date of consent*

Sex at birth:

☐ Male ☐ Female ☐ Not specified

Country of birth :

Height :

m ☐ n/a

Weight

kg ☐ n/a

BMI (automatic calculation)

SECTION 1 : Pediatrics (if applicable the link will be made automatically when the participant is under 18 years old)

Patient is an infant (less than 1 year old) ☐ No ☐ Yes (if no, go to the next section)

Weight at birth : _____ kg ☐ n/d

Gestational outcome : ☐ Term birth (>37 sem.) ☐ Preterm birth (<37 sem.) ☐ Indeterminate

SECTION 2 : Smoking and Drug Use

Smoking status : ☐ Smoker ☐ No smoker ☐ Former smoker ☐ Passive smoker
☐ Not specified

Electronic cigarettes? ☐ Yes ☐ No

Drugs? ☐ Yes ☐ No

Please specify drugs used: ☐ Cannabis ☐ Cocaine ☐ Amphetamines
☐ Opioides ☐ Others : _____

Participant type

☐ COVID positive (+) (according to PCR test) ☐ COVID negative (-) (according to PCR test) ☐ COVID undetermined (according to PCR test)

Main (or Primary) Diagnosis relative to this hospitalisation: (dx at arrival) : _____

Is the participant employed as a Healthcare Worker?

(If the participant is a child, is the parent a health worker?)

☐ No ☐ Yes ☐ N/A

Is the participant employed in a Microbiology Laboratory?

(If the participant is a child, is the parent employed in a Microbiology Laboratory?)

☐ No ☐ Yes ☐ N/A

Living where:

☐ Home ☐ Residence with services (RPA) ☐ Nursing home (CHSLD)
☐ In intermediate and family-type resources ☐ In rooming house
☐ Homeless

Living with:

☐ Family member(s) ☐ Caretaker ☐ Alone ☐ Room-mate

SECTION 1 : Obstetrics (if applicable the link will be made automatically when the participant is a female, in age to procreate)

Patient pregnant? ☐ No ☐ Yes

If yes, expected delivery date (yyyy-mm-dd) _____

Post-partum (childbirth in the last year) : ☐ No ☐ Yes

Pregnancy Outcome: ☐ Live birth ☐ Still birth

Delivery date (yyyy-mm-dd) _____

COVID status for baby : ☐ COVID positive (+) ☐ COVID negative (-) ☐ COVID underterminate

Baby tested for mother's ARI infection: ☐ No ☐ Yes If yes : ☐ Positive ☐ Negative

Method : ☐ PCR ☐ Other: _____ ☐ n/d

SECTION 2: Comments

Past medical conditions

Prior transient ischemic attack (TIA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other chronic cardiac disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic neurological disorder (other than stroke/TIA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other chronic lung disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prior Stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Malignant neoplasm?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Type :
	Metastatic ? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Actively receiving treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dementia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Atrial fibrillation or flutter?	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV ou AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arterial Hypertension?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pulmonary hypertension?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Immunosuppressed state?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prior myocardial infarction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart failure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Baseline LVEF (pre-hospitalization) %
Coronary artery disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic hematologic disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver disease? (*if described in medical records)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Malnutrition? (*if described in medical records)	<input type="checkbox"/> Yes <input type="checkbox"/> No
COPD (emphysema, chronic bronchitis)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Indeterminate
Obesity? (*if described in medical records)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatric disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic kidney disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatologic disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient have other comorbidities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other comorbidity:	Other comorbidity:
Other comorbidity:	Other comorbidity:
Other comorbidity:	Other comorbidity:
Baseline creatinine (pre-hospitalization)	μmol/l If there is a history in the medical record of the creatinine test result.

SECTION 2 : Home Medications (please refer to the help list - medication - see 6.CRF -Tools)

ACE inhibitor or Angiotensin Receptor Blocker? ☐ Yes ☐ No ☐ n/a

Systemic corticosteroid? ☐ Yes ☐ No ☐ n/a

Anticoagulants? ☐ Yes ☐ No ☐ n/a

Colchicine? ☐ Yes ☐ No ☐ n/a

HGO or insulin? ☐ Yes ☐ No ☐ n/a

Other immunosuppressive medications (includes but not limited to systemic steroid therapy, anti-rejection medications, and chemotherapy)? ☐ Yes ☐ No ☐ n/a

Please specify other immunosuppressive medication(s).

Symptoms documented on arrival at the medical record

Asymptomatic? ☐ Yes ☐ No

Date of earliest symptom(s) (yyyy-mm-dd):

Joint pain (Arthralgia)? ☐ Yes ☐ No

Confusion / altered mental status? ☐ Yes ☐ No

Red eye (Conjunctivitis)? ☐ Yes ☐ No

Seizure? ☐ Yes ☐ No

Diarrhea? ☐ Yes ☐ No

Abdominal pain? ☐ Yes ☐ No

Chest pain? ☐ Yes ☐ No

Shortness of breath (Dyspnea)? ☐ Yes ☐ No

Dizziness? ☐ Yes ☐ No

Extremity weakness or numbness? ☐ Yes ☐ No

Fatigue? ☐ Yes ☐ No

Fever ($\geq 38.0^{\circ}\text{C}$)? ☐ Yes ☐ No

Hemoptysis / Bloody sputum? ☐ Yes ☐ No

Loss of appetite? (*if described in the medical file) ☐ Yes ☐ No

Ear pain? ☐ Yes ☐ No

Sore throat? ☐ Yes ☐ No

Headache? ☐ Yes ☐ No

Muscle aches (Myalgia)? ☐ Yes ☐ No

Nausea / vomiting? ☐ Yes ☐ No

Leg swelling (Edema)? ☐ Yes ☐ No

Loss of taste / lost of smell? ☐ Yes ☐ No

Skin rash? ☐ Yes ☐ No

Runny nose (Rhinorrhea)? ☐ Yes ☐ No

Wheezing or stridor? ☐ Yes ☐ No

Cough? ☐ Yes ☐ No

Trouble speaking (Aphasia / Dysphasia)? ☐ Yes ☐ No

COVID tests and Severity

Date of FIRST test for COVID (yyyy-mm-dd)

Result : ☐ Positive ☐ Negative ☐ Equivocal

Sample type : ☐ Nasal/NP swab ☐ Throat swab ☐ Sputum ☐ Combined nasal/NP+throat swab ☐ BAL
☐ Endotracheal Aspiration ETA ☐ Urine ☐ Feces/rectal swab ☐ Blood

[Enter any other tests performed for COVID-19 below during hospitalization]

Date of test #2 for COVID (yyyy-mm-dd)

Result : ☐ Positive ☐ Negative ☐ Equivocal

Sample type : ☐ Nasal/NP swab ☐ Throat swab ☐ Sputum ☐ Combined nasal/NP+throat swab ☐ BAL
☐ Endotracheal Aspiration ETA ☐ Urine ☐ Feces/rectal swab ☐ Blood

Date of test #3 for COVID (yyyy-mm-dd)

Result : ☐ Positive ☐ Negative ☐ Equivocal

Sample type : ☐ Nasal/NP swab ☐ Throat swab ☐ Sputum ☐ Combined nasal/NP+throat swab ☐ BAL
☐ Endotracheal Aspiration ETA ☐ Urine ☐ Feces/rectal swab ☐ Blood

Date of test #4 for COVID (yyyy-mm-dd)

Result : ☐ Positive ☐ Negative ☐ Equivocal

Sample type : ☐ Nasal/NP swab ☐ Throat swab ☐ Sputum ☐ Combined nasal/NP+throat swab ☐ BAL
☐ Endotracheal Aspiration ETA ☐ Urine ☐ Feces/rectal swab ☐ Blood

Date of test #5 for COVID (yyyy-mm-dd)

Result : ☐ Positive ☐ Negative ☐ Equivocal

Sample type : ☐ Nasal/NP swab ☐ Throat swab ☐ Sputum ☐ Combined nasal/NP+throat swab ☐ BAL
☐ Endotracheal Aspiration ETA ☐ Urine ☐ Feces/rectal swab ☐ Blood

If more than 5 diagnostic tests for COVID

Test #	Date (yyyy-mm-dd)	Result	Sample type
6			
7			
8			
9			
10			

SECTION 2 : Severity

If a screening test for SARS-CoV-2 by PCR was performed, what is the most severe severity level (according to WHO) achieved?

☐ Uninfected ☐ Mild ☐ Moderate ☐ Severe ☐ Dead

Severity of the COVID-19 episode

Degree of severity	Description
Uninfected	Not infected, no viral load detected
Mild	Asymptomatic, with detected viral load Symptomatic, with detected viral load Symptomatic with need for assistance *Inpatient hospitalized for isolation only
Moderate	Inpatient hospitalized without oxygen therapy Inpatient hospitalized with oxygen therapy by mask or nasal cannula
Severe	Inpatient hospitalized with CPAP, BPAP or High flow nasal cannula oxygen therapy Inpatient hospitalized, intubated with mechanical ventilation
Dead	Deceased

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CASE REPORT FORM (CRF)

English version 03

OUTPATIENT

POST-DIAGNOSIS

(These visits are made x days SARS-CoV-2 screening test)

VERSION 18 JANVIER 2021

FOLLOW-UP VISIT 30 DAYS

Visit Description

Blood drawn for the BQC19? ☐ Yes (go to section 1) ☐ No (go to section 2)

SECTION 1 : Samples taken for BQC19

Date of blood draw (aaaa-mm-dd) _____

Time of blood draw (hh:mm) _____

Delay between the diagnosis and the draw blood Automatic calculation in REDCap (do not complete)

Collected :
☐ Ambulatory emergency
☐ Emergency stretchers
☐ Intensive Care Unit
☐ Outpatient clinic
☐ Hospital floor (specify) : _____
☐ Other (specify) : _____

SECTION 2 : No samples taken for BQC19

If no blood sample was taken for BQC19, when was the clinical data collected? (yyyy-mm-dd)? _____

Why not collected? _____

BQC19 Samples

Number of ACD tubes collected: _____

Number of PAXgene tubes collected: _____

Number of serum tubes collected: _____

Other blood draw tube(s) collected: _____

PEDIATRIC - stool collected: ☐ Yes ☐ No ☐ N/A

Were other biological samples collected? ☐ Yes ☐ No

Other sample #1 _____ Quantity : _____

Other sample #2 _____ Quantity : _____

Other sample #3 _____ Quantity : _____

Essential Follow-up

Was this follow-up visit completed?

☐ Yes ☐ No

Date of follow-up (yyyy-mm-dd) : _____

Delay between the diagnosis and the follow-up visit

Automatic calculation in REDCap (do not complete)

How was this follow-up completed?

☐ By phone

☐ In person

Who answered the questions?

Check all that apply.

☐ Patient

☐ Surrogate

☐ Health-care professional

Name of interviewer _____

SECTION 1 : Ongoing Consent

Ongoing consent status:

☐ Withdrawal from the study

☐ Partial withdrawal - consent to blood draws only

☐ Partial withdrawal - consent to follow-up only

☐ Consent to all study procedures

SECTION 2 : Vital Status Update

Date of last known vital status (yyyy-mm-dd) : _____

Vital status
☐ Alive

☐ Deceased

☐ Unknown

Follow up

Have you been diagnosed with a new or recurrent case of COVID since your last follow-up (based on PCR testing)?

☐ Yes (If the participant has had a new positive VIDOC test - please complete the End of Participation form and start a new BQC19 registration for this patient).

☐ No

Have you been re-hospitalized since your initial visit for COVID, excluding outpatient clinic visits and planned follow-up visits?

☐ Yes (go to section 1)

☐ No (go to section 2)

SECTION 1 : Medical follow-up

Have you been re-hospitalized since your initial visit for COVID-19, excluding outpatient clinic visit and planned follow-up visit? (If multiple re-hospitalization, enter the most significant one and describe the other ones in the additional comments fields at the end of the form)

☐ Yes ☐ No

Type of repeat hospital visit?

Check all that apply.

☐ Emergency room visit

☐ Hospital admission

☐ Not sure

If emergency or re-hospitalization, date of admission (yyyy-mm-dd) : _____

Facility: _____

Cause : _____

Were additional medical examinations requested as part of this follow-up? (OPTIONAL – For clinical purpose) ☐ Yes (complete the section 5) ☐ No (go to next)

Have laboratory tests been done for this day? (OPTIONAL – For clinical purpose) ☐ Yes (complete the section 6) ☐ No (go to next)

Does the participant report persistent symptoms related to SARS-CoV-2 infection? ☐ Yes (complete the section 2) ☐ No (go to next)

Has the participant had any new disease and/or worsening and/or deterioration of a pre-existing disease? ☐ Yes (complete the section 4) ☐ No (go to next)

SECTION 2 : Current symptoms

Joint pain (Arthralgia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Confusion / altered mental status?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Red eye (Conjunctivitis)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abdominal pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath (Dyspnea)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Extremity weakness or numbness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever ($\geq 38.0^{\circ}\text{C}$)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemoptysis / Bloody sputum?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headache?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle aches (Myalgia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea / vomiting ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Leg swelling (Edema) ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of taste / lost of smell?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Skin rash?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Runny nose (Rhinorrhea)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheezing or stridor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble speaking (Aphasia / Dysphasia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Functional status

Circle the correct answers

Mobility	1. I have no problems in walking about 2. I have slight problems in walking about 3. I have moderate problems in walking about 4. I have severe problems in walking about 5, I am unable to walk about
Self-care	1. I have no problem washing or dressing myself 2. I have slight problems washing or dressing myself 3. I have moderate problems washing or dressing myself 4. I have severe problems washing or dressing myself 5. am unable to wash or dress myself
Usual activities (i.e. work, study, housework, family or leisure activities)	1. I have no problems doing my usual activities 2. I have slight problems doing my usual activities 3. I have moderate problems doing my usual activities 4. I have severe problems doing my usual activities 5. I am unable to do my usual activities
Pain and discomfort	1. I have no pain or discomfort 2. I have slight pain or discomfort 3. I have moderate pain or discomfort 4. I have severe pain or discomfort 5. I have extreme pain or discomfort
Anxiety and depression	1. I am not anxious or depressed 2. I am slightly anxious or depressed 3. I am moderately anxious or depressed 4. I am severely anxious or depressed 5. I am extremely anxious or depressed
Breathlessness	1. I am breathless only with strenuous exercise 2. I am short of breath when hurrying or going up a slight hill 3. I am slower than most people of the same age on level ground 4. I stop for breath walking 100m or few minutes on level ground 5. I am too breathless to leave the house
Rate your health from 0 (worst) to 100 (best)	0 (worst / pire) 100 (best / meilleur) _____ %
How much difficulty do you have lifting or carrying 10 lbs?	1. Noe 2. Some 3. A lot or unable

How much difficulty do you have walking across a room?	1. Noe 2. Some 3. A lot or unable
How much difficulty do you have transferring from a chair to a bed?	1. Noe 2. Some 3. A lot or unable
How much difficulty do you have climbing a flight of 10 stairs?	1, Noe 2, Some 3, A lot or unable
How many times have you fallen in the past year?	0. Noe 1. 1-3 falls 2. 4 or more falls

EuroQol Group. (2011). EQ-5D-5L User Guide. Rotterdam: EuroQol Group. Available at <http://www.euroqol.org/eq-5d/publications/user-guide.html>; Nerys Williams, The MRC breathlessness scale, Occupational Medicine, 2017; 67(6): 496-497; Malmstrom TK, Morley JE. SARC-F: a simple questionnaire to rapidly diagnose sarcopenia. J Am Med Dir Assoc. 2013;14(8):531-532.

SECTION 4 : Complications Post-COVID

Cardiovascular complications?

- ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection

- ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Cardiac arrest?	<input type="checkbox"/>	<input type="checkbox"/>
Other cardiac arrhythmia?	<input type="checkbox"/>	<input type="checkbox"/>
Endocarditis? Myocarditis? Pericarditis?	<input type="checkbox"/>	<input type="checkbox"/>
New atrial fibrillation or flutter (FA)?	<input type="checkbox"/>	<input type="checkbox"/>
Ventricular tachycardia or fibrillation (VT/VF)?	<input type="checkbox"/>	<input type="checkbox"/>
Left ventricular fonction?	<input type="checkbox"/>	<input type="checkbox"/>
Decompensated heart failure??	<input type="checkbox"/>	<input type="checkbox"/>
Non-ST-elevation myocardial infarction (NSTEMI)? ST-elevation myocardial infarction (STEMI)?	<input type="checkbox"/>	<input type="checkbox"/>
Deep vein thrombosis (DVT)?	<input type="checkbox"/>	<input type="checkbox"/>
Dissiminated intravascular coagulation?	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory complications?

- ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection

- ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Bronchiolitis?	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary embolism (PE)?	<input type="checkbox"/>	<input type="checkbox"/>
Pleural effusion?	<input type="checkbox"/>	<input type="checkbox"/>
Interstitial lung disease?	<input type="checkbox"/>	<input type="checkbox"/>
COPD?	<input type="checkbox"/>	<input type="checkbox"/>
Bacterial, viral or cryptogenic organizing pneumonia?	<input type="checkbox"/>	<input type="checkbox"/>
Pneumothorax?	<input type="checkbox"/>	<input type="checkbox"/>
Acute Respiratory Distress Syndrome (ARDS)?	<input type="checkbox"/>	<input type="checkbox"/>

Renal complications? ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Acute kidney injury?	<input type="checkbox"/>	<input type="checkbox"/>

Neurologic complications? ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
TIA? Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Seizure?	<input type="checkbox"/>	<input type="checkbox"/>
Méningitis / encephalitis?	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with concentration?	<input type="checkbox"/>	<input type="checkbox"/>
Memory problem? Brain Fog?	<input type="checkbox"/>	<input type="checkbox"/>

Psychiatric complications? ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Depression?	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety?	<input type="checkbox"/>	<input type="checkbox"/>
Mood change?	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal complications?		<input type="checkbox"/> Yes (complete the section)
		<input type="checkbox"/> No (go to next)
Connection with SARS-CoV-2 infection	<input type="checkbox"/> Recently appeared and directly linked to COVID-19 episode <input type="checkbox"/> Pathology already present but worsening / deterioration <input type="checkbox"/> Note related to SARS-CoV-2 infection <input type="checkbox"/> Undetermined	
	No	Yes
Liver dysfunction?	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal heamorrhage?	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatitis?	<input type="checkbox"/>	<input type="checkbox"/>

Complications of the endocrine system?		<input type="checkbox"/> Yes (complete the section)
		<input type="checkbox"/> No (go to next)
Connection with SARS-CoV-2 infection	<input type="checkbox"/> Recently appeared and directly linked to COVID-19 episode <input type="checkbox"/> Pathology already present but worsening / deterioration <input type="checkbox"/> Note related to SARS-CoV-2 infection <input type="checkbox"/> Undetermined	
	No	Yes
Hyperglycemia?	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia?	<input type="checkbox"/>	<input type="checkbox"/>

Others complications?		<input type="checkbox"/> Yes (complete the section)
		<input type="checkbox"/> No (go to next)
Connection with SARS-CoV-2 infection	<input type="checkbox"/> Recently appeared and directly linked to COVID-19 episode <input type="checkbox"/> Pathology already present but worsening / deterioration <input type="checkbox"/> Note related to SARS-CoV-2 infection <input type="checkbox"/> Undetermined	
	No	Yes
Anemia?	<input type="checkbox"/>	<input type="checkbox"/>
Bacteriemia?	<input type="checkbox"/>	<input type="checkbox"/>
Rhabdomyolysis or myositis?	<input type="checkbox"/>	<input type="checkbox"/>
Others	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 5 : Tests	
Medical context of the requested follow-up examinations	
Cardiac assessment	
Coronary angiography (Cardiac catheterization)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Point of care ultrasound (POCUS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Echocardiogram?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Electrocardiogram (EKG)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Percutaneous coronary intervention ("stented")?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical imaging	
Chest X-ray?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT Abdomen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT Thorax?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT Head?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other imaging test(s)?	
Respiratory function tests	
Spirometry?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Metacholine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung function test?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 6 : Labs Follow up

OPTIONAL - To be completed if the participant had routine laboratories as part of their follow-up. These tests are MANDATORY.

IgG			
Total WBC count	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured
Neutrophil count	_____	%	<input type="checkbox"/> Not measured
Lymphocyte count	_____	%	<input type="checkbox"/> Not measured
Monocyte count	_____	%	<input type="checkbox"/> Not measured
Eosinophil count	_____	%	<input type="checkbox"/> Not measured
Basophil count	_____	%	<input type="checkbox"/> Not measured
Platelets	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured
Haemoglobin	_____	g/L	<input type="checkbox"/> Not measured
Urea	_____	mmol/L	<input type="checkbox"/> Not measured
Creatinine	_____	μmol/L	<input type="checkbox"/> Not measured
NT-proBNP	_____	ng/L	<input type="checkbox"/> Not measured
BNP	_____	ng/L	<input type="checkbox"/> Not measured
Sodium Na+	_____	mmol/L	<input type="checkbox"/> Not measured
Potassium K+	_____	mmol/L	<input type="checkbox"/> Not measured
C-reactive protein (CRP)	_____	mg/L	<input type="checkbox"/> Not measured
LDH	_____	U/L	<input type="checkbox"/> Not measured
Creatine Phosphokinase (CPK)	_____	U/L	<input type="checkbox"/> Not measured
Albumin	_____	g/L	<input type="checkbox"/> Not measured

AST	_____	U/L	<input type="checkbox"/> Not measured
ALT	_____	U/L	<input type="checkbox"/> Not measured
Procalcitonin (PCT)	_____	µg/L	<input type="checkbox"/> Not measured
Troponin T hs (high sensitivity)	_____	ng/L	<input type="checkbox"/> Not measured
Troponin I hs (high sensitivity)	_____	ng/L	<input type="checkbox"/> Not measured
Troponin T	_____	ng/L	<input type="checkbox"/> Not measured
Troponin I	_____	ng/L	<input type="checkbox"/> Not measured
APTT (activated partial thromboplastin time)	_____	sec	<input type="checkbox"/> Not measured
International Normalized Ratio (INR)	_____		<input type="checkbox"/> Not measured
Triglycerides	_____	mmol/L	<input type="checkbox"/> Not measured
Total bilirubin	_____	µmol/L	<input type="checkbox"/> Not measured
Direct bilirubin (conjugated)	_____	µmol/L	<input type="checkbox"/> Not measured
Glucose	_____	mmol/L	<input type="checkbox"/> Not measured
Fibrinogen	_____	g/L	<input type="checkbox"/> Not measured
Ferritin	_____	µg/L	<input type="checkbox"/> Not measured
IL-6	_____	ng/L	<input type="checkbox"/> Not measured
CD4	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured
CD8	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured

SECTION 7 : Clinical frailty score

Frailty scale (clinical frailty scale) (circle) 1 2 3 4 5 6 7 8 9 ☐ n/d

Clinical Frailty Scale*



1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.



2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.



3 Managing Well – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.



4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up", and/or being tired during the day.



5 Mildly Frail – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.



6 Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.



7 Severely Frail – Completely dependent for **personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).



8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.



9. Terminally Ill - Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rodwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173:489-495.

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FOLLOW-UP VISIT 90 DAYS

Visit Description

Blood drawn for the BQC19? ☐ Yes (go to section 1) ☐ No (go to section 2)

SECTION 1 : Samples taken for BQC19

Date of blood draw (aaaa-mm-dd) _____

Time of blood draw (hh:mm) _____

Delay between the diagnosis and the draw blood Automatic calculation in REDCap (do not complete)

Collected :
☐ Ambulatory emergency
☐ Emergency stretchers
☐ Intensive Care Unit
☐ Outpatient clinic
☐ Hospital floor (specify) : _____
☐ Other (specify) : _____

SECTION 2 : No samples taken for BQC19

If no blood sample was taken for BQC19, when was the clinical data collected? (yyyy-mm-dd)? _____

Why not collected? _____

BQC19 Samples

Number of ACD tubes collected: _____

Number of PAXgene tubes collected: _____

Number of serum tubes collected: _____

Other blood draw tube(s) collected: _____

PEDIATRIC - stool collected: ☐ Yes ☐ No ☐ N/A

Were other biological samples collected? ☐ Yes ☐ No

Other sample #1 _____ Quantity : _____

Other sample #2 _____ Quantity : _____

Other sample #3 _____ Quantity : _____

Essential Follow-up

Was this follow-up visit completed?

☐ Yes ☐ No

Date of follow-up (yyyy-mm-dd) : _____

Delay between the diagnosis and the follow-up visit

Automatic calculation in REDCap (do not complete)

How was this follow-up completed?

☐ By phone

☐ In person

Who answered the questions?

Check all that apply.

☐ Patient

☐ Surrogate

☐ Health-care professional

Name of interviewer _____

SECTION 1 : Ongoing Consent

Ongoing consent status:

☐ Withdrawal from the study

☐ Partial withdrawal - consent to blood draws only

☐ Partial withdrawal - consent to follow-up only

☐ Consent to all study procedures

SECTION 2 : Vital Status Update

Date of last known vital status (yyyy-mm-dd) : _____

Vital status
☐ Alive

☐ Deceased

☐ Unknown

Follow up

Have you been diagnosed with a new or recurrent case of COVID since your last follow-up (based on PCR testing)?

☐ Yes (If the participant has had a new positive VIDOC test - please complete the End of Participation form and start a new BQC19 registration for this patient).

☐ No

Have you been re-hospitalized since your initial visit for COVID, excluding outpatient clinic visits and planned follow-up visits?

☐ Yes (go to section 1)

☐ No (go to section 2)

SECTION 1 : Medical follow-up

Have you been re-hospitalized since your initial visit for COVID-19, excluding outpatient clinic visit and planned follow-up visit? (If multiple re-hospitalization, enter the most significant one and describe the other ones in the additional comments fields at the end of the form)

☐ Yes ☐ No

Type of repeat hospital visit?

Check all that apply.

☐ Emergency room visit

☐ Hospital admission

☐ Not sure

If emergency or re-hospitalization, date of admission (yyyy-mm-dd) : _____

Facility: _____

Cause : _____

Were additional medical examinations requested as part of this follow-up? (OPTIONAL – For clinical purpose) ☐ Yes (complete the section 5) ☐ No (go to next)

Have laboratory tests been done for this day? (OPTIONAL – For clinical purpose) ☐ Yes (complete the section 6) ☐ No (go to next)

Does the participant report persistent symptoms related to SARS-CoV-2 infection? ☐ Yes (complete the section 2) ☐ No (go to next)

Has the participant had any new disease and/or worsening and/or deterioration of a pre-existing disease? ☐ Yes (complete the section 4) ☐ No (go to next)

SECTION 2 : Current symptoms

Joint pain (Arthralgia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Confusion / altered mental status?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Red eye (Conjunctivitis)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abdominal pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath (Dyspnea)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Extremity weakness or numbness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever ($\geq 38.0^{\circ}\text{C}$)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemoptysis / Bloody sputum?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headache?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle aches (Myalgia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea / vomiting ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Leg swelling (Edema) ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of taste / lost of smell?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Skin rash?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Runny nose (Rhinorrhea)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheezing or stridor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble speaking (Aphasia / Dysphasia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Functional status

Circle the correct answers

Mobility	1. I have no problems in walking about 2. I have slight problems in walking about 3. I have moderate problems in walking about 4. I have severe problems in walking about 5, I am unable to walk about
Self-care	1. I have no problem washing or dressing myself 2. I have slight problems washing or dressing myself 3. I have moderate problems washing or dressing myself 4. I have severe problems washing or dressing myself 5. am unable to wash or dress myself
Usual activities (i.e. work, study, housework, family or leisure activities)	1. I have no problems doing my usual activities 2. I have slight problems doing my usual activities 3. I have moderate problems doing my usual activities 4. I have severe problems doing my usual activities 5. I am unable to do my usual activities
Pain and discomfort	1. I have no pain or discomfort 2. I have slight pain or discomfort 3. I have moderate pain or discomfort 4. I have severe pain or discomfort 5. I have extreme pain or discomfort
Anxiety and depression	1. I am not anxious or depressed 2. I am slightly anxious or depressed 3. I am moderately anxious or depressed 4. I am severely anxious or depressed 5. I am extremely anxious or depressed
Breathlessness	1. I am breathless only with strenuous exercise 2. I am short of breath when hurrying or going up a slight hill 3. I am slower than most people of the same age on level ground 4. I stop for breath walking 100m or few minutes on level ground 5. I am too breathless to leave the house
Rate your health from 0 (worst) to 100 (best)	0 (worst / pire) 100 (best / meilleur) _____ %
How much difficulty do you have lifting or carrying 10 lbs?	1. Noe 2. Some 3. A lot or unable

How much difficulty do you have walking across a room?	1. Noe 2. Some 3. A lot or unable
How much difficulty do you have transferring from a chair to a bed?	1. Noe 2. Some 3. A lot or unable
How much difficulty do you have climbing a flight of 10 stairs?	1, Noe 2, Some 3, A lot or unable
How many times have you fallen in the past year?	0. Noe 1. 1-3 falls 2. 4 or more falls

EuroQol Group. (2011). EQ-5D-5L User Guide. Rotterdam: EuroQol Group. Available at <http://www.euroqol.org/eq-5d/publications/user-guide.html>; Nerys Williams, The MRC breathlessness scale, Occupational Medicine, 2017; 67(6): 496-497; Malmstrom TK, Morley JE. SARC-F: a simple questionnaire to rapidly diagnose sarcopenia. J Am Med Dir Assoc. 2013;14(8):531-532.

SECTION 4 : Complications Post-COVID

Cardiovascular complications?

- ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection

- ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Cardiac arrest?	<input type="checkbox"/>	<input type="checkbox"/>
Other cardiac arrhythmia?	<input type="checkbox"/>	<input type="checkbox"/>
Endocarditis? Myocarditis? Pericarditis?	<input type="checkbox"/>	<input type="checkbox"/>
New atrial fibrillation or flutter (FA)?	<input type="checkbox"/>	<input type="checkbox"/>
Ventricular tachycardia or fibrillation (VT/VF)?	<input type="checkbox"/>	<input type="checkbox"/>
Left ventricular fonction?	<input type="checkbox"/>	<input type="checkbox"/>
Decompensated heart failure??	<input type="checkbox"/>	<input type="checkbox"/>
Non-ST-elevation myocardial infarction (NSTEMI)? ST-elevation myocardial infarction (STEMI)?	<input type="checkbox"/>	<input type="checkbox"/>
Deep vein thrombosis (DVT)?	<input type="checkbox"/>	<input type="checkbox"/>
Dissiminated intravascular coagulation?	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory complications?

- ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection

- ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Bronchiolitis?	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary embolism (PE)?	<input type="checkbox"/>	<input type="checkbox"/>
Pleural effusion?	<input type="checkbox"/>	<input type="checkbox"/>
Interstitial lung disease?	<input type="checkbox"/>	<input type="checkbox"/>
COPD?	<input type="checkbox"/>	<input type="checkbox"/>
Bacterial, viral or cryptogenic organizing pneumonia?	<input type="checkbox"/>	<input type="checkbox"/>
Pneumothorax?	<input type="checkbox"/>	<input type="checkbox"/>
Acute Respiratory Distress Syndrome (ARDS)?	<input type="checkbox"/>	<input type="checkbox"/>

Renal complications? ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Acute kidney injury?	<input type="checkbox"/>	<input type="checkbox"/>

Neurologic complications? ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
TIA? Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Seizure?	<input type="checkbox"/>	<input type="checkbox"/>
Méningitis / encephalitis?	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with concentration?	<input type="checkbox"/>	<input type="checkbox"/>
Memory problem? Brain Fog?	<input type="checkbox"/>	<input type="checkbox"/>

Psychiatric complications? ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Depression?	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety?	<input type="checkbox"/>	<input type="checkbox"/>
Mood change?	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal complications?	<input type="checkbox"/> Yes (complete the section) <input type="checkbox"/> No (go to next)												
Connection with SARS-CoV-2 infection	<input type="checkbox"/> Recently appeared and directly linked to COVID-19 episode <input type="checkbox"/> Pathology already present but worsening / deterioration <input type="checkbox"/> Note related to SARS-CoV-2 infection <input type="checkbox"/> Undetermined												
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Gastrointestinal heamorrhage?	<input type="checkbox"/>	<input type="checkbox"/>											
Pancreatitis?	<input type="checkbox"/>	<input type="checkbox"/>											

Complications of the endocrine system?	<input type="checkbox"/> Yes (complete the section) <input type="checkbox"/> No (go to next)									
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	No	Yes								
Hyperglycemia?	<input type="checkbox"/>	<input type="checkbox"/>								
Hypoglycemia?	<input type="checkbox"/>	<input type="checkbox"/>								

Others complications?	<input type="checkbox"/> Yes (complete the section) <input type="checkbox"/> No (go to next)																					
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Rhabdomyolysis or myositis?	<input type="checkbox"/>	<input type="checkbox"/>																				
Others	<input type="checkbox"/>	<input type="checkbox"/>																				

SECTION 5 : Tests

Medical context of the requested follow-up examinations

Cardiac assessment

Coronary angiography (Cardiac catheterization)? ☐ Yes ☐ No

Point of care ultrasound (POCUS)? ☐ Yes ☐ No

Echocardiogram? ☐ Yes ☐ No

Electrocardiogram (EKG)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Percutaneous coronary intervention ("stented")?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical imaging	
Chest X-ray?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT Abdomen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT Thorax?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT Head?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other imaging test(s)?	
Respiratory function tests	
Spirometry?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Metacholine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung function test?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 6 : Labs Follow up

OPTIONAL - To be completed if the participant had routine laboratories as part of their follow-up. These tests are MANDATORY.

IgG			
Total WBC count	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured
Neutrophil count	_____	%	<input type="checkbox"/> Not measured
Lymphocyte count	_____	%	<input type="checkbox"/> Not measured
Monocyte count	_____	%	<input type="checkbox"/> Not measured
Eosinophil count	_____	%	<input type="checkbox"/> Not measured
Basophil count	_____	%	<input type="checkbox"/> Not measured
Platelets	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured
Haemoglobin	_____	g/L	<input type="checkbox"/> Not measured
Urea	_____	mmol/L	<input type="checkbox"/> Not measured
Creatinine	_____	μmol/L	<input type="checkbox"/> Not measured
NT-proBNP	_____	ng/L	<input type="checkbox"/> Not measured
BNP	_____	ng/L	<input type="checkbox"/> Not measured
Sodium Na+	_____	mmol/L	<input type="checkbox"/> Not measured
Potassium K+	_____	mmol/L	<input type="checkbox"/> Not measured
C-reactive protein (CRP)	_____	mg/L	<input type="checkbox"/> Not measured
LDH	_____	U/L	<input type="checkbox"/> Not measured
Creatine Phosphokinase (CPK)	_____	U/L	<input type="checkbox"/> Not measured
Albumin	_____	g/L	<input type="checkbox"/> Not measured

AST	_____	U/L	<input type="checkbox"/> Not measured
ALT	_____	U/L	<input type="checkbox"/> Not measured
Procalcitonin (PCT)	_____	µg/L	<input type="checkbox"/> Not measured
Troponin T hs (high sensitivity)	_____	ng/L	<input type="checkbox"/> Not measured
Troponin I hs (high sensitivity)	_____	ng/L	<input type="checkbox"/> Not measured
Troponin T	_____	ng/L	<input type="checkbox"/> Not measured
Troponin I	_____	ng/L	<input type="checkbox"/> Not measured
APTT (activated partial thromboplastin time)	_____	sec	<input type="checkbox"/> Not measured
International Normalized Ratio (INR)	_____		<input type="checkbox"/> Not measured
Triglycerides	_____	mmol/L	<input type="checkbox"/> Not measured
Total bilirubin	_____	µmol/L	<input type="checkbox"/> Not measured
Direct bilirubin (conjugated)	_____	µmol/L	<input type="checkbox"/> Not measured
Glucose	_____	mmol/L	<input type="checkbox"/> Not measured
Fibrinogen	_____	g/L	<input type="checkbox"/> Not measured
Ferritin	_____	µg/L	<input type="checkbox"/> Not measured
IL-6	_____	ng/L	<input type="checkbox"/> Not measured
CD4	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured
CD8	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured

SECTION 7 : Clinical frailty score

Frailty scale (clinical frailty scale) (circle) 1 2 3 4 5 6 7 8 9 ☐ n/d

Clinical Frailty Scale*



1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.



2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.



3 Managing Well – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.



4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up", and/or being tired during the day.



5 Mildly Frail – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.



6 Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.



7 Severely Frail – Completely dependent for **personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).



8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.



9. Terminally Ill - Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rodwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173:489-495.

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FOLLOW-UP VISIT 180 DAYS

Visit Description

Blood drawn for the BQC19? ☐ Yes (go to section 1) ☐ No (go to section 2)

SECTION 1 : Samples taken for BQC19

Date of blood draw (aaaa-mm-dd) _____

Time of blood draw (hh:mm) _____

Delay between the diagnosis and the draw blood Automatic calculation in REDCap (do not complete)

Collected :
☐ Ambulatory emergency
☐ Emergency stretchers
☐ Intensive Care Unit
☐ Outpatient clinic
☐ Hospital floor (specify) : _____
☐ Other (specify) : _____

SECTION 2 : No samples taken for BQC19

If no blood sample was taken for BQC19, when was the clinical data collected? (yyyy-mm-dd)? _____

Why not collected? _____

BQC19 Samples

Number of ACD tubes collected: _____

Number of PAXgene tubes collected: _____

Number of serum tubes collected: _____

Other blood draw tube(s) collected: _____

PEDIATRIC - stool collected: ☐ Yes ☐ No ☐ N/A

Were other biological samples collected? ☐ Yes ☐ No

Other sample #1 _____ Quantity : _____

Other sample #2 _____ Quantity : _____

Other sample #3 _____ Quantity : _____

Essential Follow-up

Was this follow-up visit completed?

☐ Yes ☐ No

Date of follow-up (yyyy-mm-dd) : _____

Delay between the diagnosis and the follow-up visit

Automatic calculation in REDCap (do not complete)

How was this follow-up completed?

☐ By phone

☐ In person

Who answered the questions?

Check all that apply.

☐ Patient

☐ Surrogate

☐ Health-care professional

Name of interviewer _____

SECTION 1 : Ongoing Consent

Ongoing consent status:

☐ Withdrawal from the study

☐ Partial withdrawal - consent to blood draws only

☐ Partial withdrawal - consent to follow-up only

☐ Consent to all study procedures

SECTION 2 : Vital Status Update

Date of last known vital status (yyyy-mm-dd) : _____

Vital status
☐ Alive

☐ Deceased

☐ Unknown

Follow up

Have you been diagnosed with a new or recurrent case of COVID since your last follow-up (based on PCR testing)?

☐ Yes (If the participant has had a new positive VIDOC test - please complete the End of Participation form and start a new BQC19 registration for this patient).

☐ No

Have you been re-hospitalized since your initial visit for COVID, excluding outpatient clinic visits and planned follow-up visits?

☐ Yes (go to section 1)

☐ No (go to section 2)

SECTION 1 : Medical follow-up

Have you been re-hospitalized since your initial visit for COVID-19, excluding outpatient clinic visit and planned follow-up visit? (If multiple re-hospitalization, enter the most significant one and describe the other ones in the additional comments fields at the end of the form)

☐ Yes ☐ No

Type of repeat hospital visit?

Check all that apply.

☐ Emergency room visit

☐ Hospital admission

☐ Not sure

If emergency or re-hospitalization, date of admission (yyyy-mm-dd) : _____

Facility: _____

Cause : _____

Were additional medical examinations requested as part of this follow-up? (OPTIONAL – For clinical purpose) ☐ Yes (complete the section 5) ☐ No (go to next)

Have laboratory tests been done for this day? (OPTIONAL – For clinical purpose) ☐ Yes (complete the section 6) ☐ No (go to next)

Does the participant report persistent symptoms related to SARS-CoV-2 infection? ☐ Yes (complete the section 2) ☐ No (go to next)

Has the participant had any new disease and/or worsening and/or deterioration of a pre-existing disease? ☐ Yes (complete the section 4) ☐ No (go to next)

SECTION 2 : Current symptoms

Joint pain (Arthralgia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Confusion / altered mental status?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Red eye (Conjunctivitis)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abdominal pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath (Dyspnea)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Extremity weakness or numbness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever ($\geq 38.0^{\circ}\text{C}$)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemoptysis / Bloody sputum?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headache?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle aches (Myalgia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea / vomiting ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Leg swelling (Edema) ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of taste / lost of smell?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Skin rash?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Runny nose (Rhinorrhea)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheezing or stridor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble speaking (Aphasia / Dysphasia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Functional status

Circle the correct answers

Mobility	1. I have no problems in walking about 2. I have slight problems in walking about 3. I have moderate problems in walking about 4. I have severe problems in walking about 5, I am unable to walk about
Self-care	1. I have no problem washing or dressing myself 2. I have slight problems washing or dressing myself 3. I have moderate problems washing or dressing myself 4. I have severe problems washing or dressing myself 5. am unable to wash or dress myself
Usual activities (i.e. work, study, housework, family or leisure activities)	1. I have no problems doing my usual activities 2. I have slight problems doing my usual activities 3. I have moderate problems doing my usual activities 4. I have severe problems doing my usual activities 5. I am unable to do my usual activities
Pain and discomfort	1. I have no pain or discomfort 2. I have slight pain or discomfort 3. I have moderate pain or discomfort 4. I have severe pain or discomfort 5. I have extreme pain or discomfort
Anxiety and depression	1. I am not anxious or depressed 2. I am slightly anxious or depressed 3. I am moderately anxious or depressed 4. I am severely anxious or depressed 5. I am extremely anxious or depressed
Breathlessness	1. I am breathless only with strenuous exercise 2. I am short of breath when hurrying or going up a slight hill 3. I am slower than most people of the same age on level ground 4. I stop for breath walking 100m or few minutes on level ground 5. I am too breathless to leave the house
Rate your health from 0 (worst) to 100 (best)	0 (worst / pire) 100 (best / meilleur) _____ %
How much difficulty do you have lifting or carrying 10 lbs?	1. Noe 2. Some 3. A lot or unable

How much difficulty do you have walking across a room?	1. Noe 2. Some 3. A lot or unable
How much difficulty do you have transferring from a chair to a bed?	1. Noe 2. Some 3. A lot or unable
How much difficulty do you have climbing a flight of 10 stairs?	1, Noe 2, Some 3, A lot or unable
How many times have you fallen in the past year?	0. Noe 1. 1-3 falls 2. 4 or more falls

EuroQol Group. (2011). EQ-5D-5L User Guide. Rotterdam: EuroQol Group. Available at <http://www.euroqol.org/eq-5d/publications/user-guide.html>; Nerys Williams, The MRC breathlessness scale, Occupational Medicine, 2017; 67(6): 496-497; Malmstrom TK, Morley JE. SARC-F: a simple questionnaire to rapidly diagnose sarcopenia. J Am Med Dir Assoc. 2013;14(8):531-532.

SECTION 4 : Complications Post-COVID

Cardiovascular complications?

- ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection

- ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Cardiac arrest?	<input type="checkbox"/>	<input type="checkbox"/>
Other cardiac arrhythmia?	<input type="checkbox"/>	<input type="checkbox"/>
Endocarditis? Myocarditis? Pericarditis?	<input type="checkbox"/>	<input type="checkbox"/>
New atrial fibrillation or flutter (FA)?	<input type="checkbox"/>	<input type="checkbox"/>
Ventricular tachycardia or fibrillation (VT/VF)?	<input type="checkbox"/>	<input type="checkbox"/>
Left ventricular fonction?	<input type="checkbox"/>	<input type="checkbox"/>
Decompensated heart failure??	<input type="checkbox"/>	<input type="checkbox"/>
Non-ST-elevation myocardial infarction (NSTEMI)? ST-elevation myocardial infarction (STEMI)?	<input type="checkbox"/>	<input type="checkbox"/>
Deep vein thrombosis (DVT)?	<input type="checkbox"/>	<input type="checkbox"/>
Dissiminated intravascular coagulation?	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory complications?

- ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection

- ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Bronchiolitis?	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary embolism (PE)?	<input type="checkbox"/>	<input type="checkbox"/>
Pleural effusion?	<input type="checkbox"/>	<input type="checkbox"/>
Interstitial lung disease?	<input type="checkbox"/>	<input type="checkbox"/>
COPD?	<input type="checkbox"/>	<input type="checkbox"/>
Bacterial, viral or cryptogenic organizing pneumonia?	<input type="checkbox"/>	<input type="checkbox"/>
Pneumothorax?	<input type="checkbox"/>	<input type="checkbox"/>
Acute Respiratory Distress Syndrome (ARDS)?	<input type="checkbox"/>	<input type="checkbox"/>

Renal complications? ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Acute kidney injury?	<input type="checkbox"/>	<input type="checkbox"/>

Neurologic complications? ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
TIA? Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Seizure?	<input type="checkbox"/>	<input type="checkbox"/>
Méningitis / encephalitis?	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with concentration?	<input type="checkbox"/>	<input type="checkbox"/>
Memory problem? Brain Fog?	<input type="checkbox"/>	<input type="checkbox"/>

Psychiatric complications? ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Depression?	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety?	<input type="checkbox"/>	<input type="checkbox"/>
Mood change?	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal complications?	<input type="checkbox"/> Yes (complete the section) <input type="checkbox"/> No (go to next)												
Connection with SARS-CoV-2 infection	<input type="checkbox"/> Recently appeared and directly linked to COVID-19 episode <input type="checkbox"/> Pathology already present but worsening / deterioration <input type="checkbox"/> Note related to SARS-CoV-2 infection <input type="checkbox"/> Undetermined												
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Pancreatitis?	<input type="checkbox"/>	<input type="checkbox"/>											

Complications of the endocrine system?	<input type="checkbox"/> Yes (complete the section) <input type="checkbox"/> No (go to next)									
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	No	Yes								
Hyperglycemia?	<input type="checkbox"/>	<input type="checkbox"/>								
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Others complications?	<input type="checkbox"/> Yes (complete the section) <input type="checkbox"/> No (go to next)																					
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Others	<input type="checkbox"/>	<input type="checkbox"/>																				

SECTION 5 : Tests

Medical context of the requested follow-up examinations

Cardiac assessment

Coronary angiography (Cardiac catheterization)? ☐ Yes ☐ No

Point of care ultrasound (POCUS)? ☐ Yes ☐ No

Echocardiogram? ☐ Yes ☐ No

Electrocardiogram (EKG)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Percutaneous coronary intervention ("stented")?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical imaging	
Chest X-ray?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT Abdomen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT Thorax?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT Head?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other imaging test(s)?	
Respiratory function tests	
Spirometry?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Metacholine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung function test?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 6 : Labs Follow up

OPTIONAL - To be completed if the participant had routine laboratories as part of their follow-up. These tests are MANDATORY.

IgG			
Total WBC count	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured
Neutrophil count	_____	%	<input type="checkbox"/> Not measured
Lymphocyte count	_____	%	<input type="checkbox"/> Not measured
Monocyte count	_____	%	<input type="checkbox"/> Not measured
Eosinophil count	_____	%	<input type="checkbox"/> Not measured
Basophil count	_____	%	<input type="checkbox"/> Not measured
Platelets	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured
Haemoglobin	_____	g/L	<input type="checkbox"/> Not measured
Urea	_____	mmol/L	<input type="checkbox"/> Not measured
Creatinine	_____	μmol/L	<input type="checkbox"/> Not measured
NT-proBNP	_____	ng/L	<input type="checkbox"/> Not measured
BNP	_____	ng/L	<input type="checkbox"/> Not measured
Sodium Na+	_____	mmol/L	<input type="checkbox"/> Not measured
Potassium K+	_____	mmol/L	<input type="checkbox"/> Not measured
C-reactive protein (CRP)	_____	mg/L	<input type="checkbox"/> Not measured
LDH	_____	U/L	<input type="checkbox"/> Not measured
Creatine Phosphokinase (CPK)	_____	U/L	<input type="checkbox"/> Not measured
Albumin	_____	g/L	<input type="checkbox"/> Not measured

AST	_____	U/L	<input type="checkbox"/> Not measured
ALT	_____	U/L	<input type="checkbox"/> Not measured
Procalcitonin (PCT)	_____	µg/L	<input type="checkbox"/> Not measured
Troponin T hs (high sensitivity)	_____	ng/L	<input type="checkbox"/> Not measured
Troponin I hs (high sensitivity)	_____	ng/L	<input type="checkbox"/> Not measured
Troponin T	_____	ng/L	<input type="checkbox"/> Not measured
Troponin I	_____	ng/L	<input type="checkbox"/> Not measured
APTT (activated partial thromboplastin time)	_____	sec	<input type="checkbox"/> Not measured
International Normalized Ratio (INR)	_____		<input type="checkbox"/> Not measured
Triglycerides	_____	mmol/L	<input type="checkbox"/> Not measured
Total bilirubin	_____	µmol/L	<input type="checkbox"/> Not measured
Direct bilirubin (conjugated)	_____	µmol/L	<input type="checkbox"/> Not measured
Glucose	_____	mmol/L	<input type="checkbox"/> Not measured
Fibrinogen	_____	g/L	<input type="checkbox"/> Not measured
Ferritin	_____	µg/L	<input type="checkbox"/> Not measured
IL-6	_____	ng/L	<input type="checkbox"/> Not measured
CD4	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured
CD8	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured

SECTION 7 : Clinical frailty score

Frailty scale (clinical frailty scale) (circle) 1 2 3 4 5 6 7 8 9 ☐ n/d

Clinical Frailty Scale*



1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.



2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.



3 Managing Well – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.



4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up", and/or being tired during the day.



5 Mildly Frail – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.



6 Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.



7 Severely Frail – Completely dependent for **personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).



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9. Terminally Ill - Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

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FOLLOW-UP VISIT 365 DAYS

Visit Description

Blood drawn for the BQC19? ☐ Yes (go to section 1) ☐ No (go to section 2)

SECTION 1 : Samples taken for BQC19

Date of blood draw (aaaa-mm-dd) _____

Time of blood draw (hh:mm) _____

Delay between the diagnosis and the draw blood Automatic calculation in REDCap (do not complete)

Collected :
☐ Ambulatory emergency
☐ Emergency stretchers
☐ Intensive Care Unit
☐ Outpatient clinic
☐ Hospital floor (specify) : _____
☐ Other (specify) : _____

SECTION 2 : No samples taken for BQC19

If no blood sample was taken for BQC19, when was the clinical data collected? (yyyy-mm-dd)? _____

Why not collected? _____

BQC19 Samples

Number of ACD tubes collected: _____

Number of PAXgene tubes collected: _____

Number of serum tubes collected: _____

Other blood draw tube(s) collected: _____

PEDIATRIC - stool collected: ☐ Yes ☐ No ☐ N/A

Were other biological samples collected? ☐ Yes ☐ No

Other sample #1 _____ Quantity : _____

Other sample #2 _____ Quantity : _____

Other sample #3 _____ Quantity : _____

Essential Follow-up

Was this follow-up visit completed?

☐ Yes ☐ No

Date of follow-up (yyyy-mm-dd) : _____

Delay between the diagnosis and the follow-up visit

Automatic calculation in REDCap (do not complete)

How was this follow-up completed?

☐ By phone

☐ In person

Who answered the questions?

Check all that apply.

☐ Patient

☐ Surrogate

☐ Health-care professional

Name of interviewer _____

SECTION 1 : Ongoing Consent

Ongoing consent status:

☐ Withdrawal from the study

☐ Partial withdrawal - consent to blood draws only

☐ Partial withdrawal - consent to follow-up only

☐ Consent to all study procedures

SECTION 2 : Vital Status Update

Date of last known vital status (yyyy-mm-dd) : _____

Vital status
☐ Alive

☐ Deceased

☐ Unknown

Follow up

Have you been diagnosed with a new or recurrent case of COVID since your last follow-up (based on PCR testing)?

☐ Yes (If the participant has had a new positive VIDOC test - please complete the End of Participation form and start a new BQC19 registration for this patient).

☐ No

Have you been re-hospitalized since your initial visit for COVID, excluding outpatient clinic visits and planned follow-up visits?

☐ Yes (go to section 1)

☐ No (go to section 2)

SECTION 1 : Medical follow-up

Have you been re-hospitalized since your initial visit for COVID-19, excluding outpatient clinic visit and planned follow-up visit? (If multiple re-hospitalization, enter the most significant one and describe the other ones in the additional comments fields at the end of the form)

☐ Yes ☐ No

Type of repeat hospital visit?

Check all that apply.

☐ Emergency room visit

☐ Hospital admission

☐ Not sure

If emergency or re-hospitalization, date of admission (yyyy-mm-dd) : _____

Facility: _____

Cause : _____

Were additional medical examinations requested as part of this follow-up? (OPTIONAL – For clinical purpose) ☐ Yes (complete the section 5) ☐ No (go to next)

Have laboratory tests been done for this day? (OPTIONAL – For clinical purpose) ☐ Yes (complete the section 6) ☐ No (go to next)

Does the participant report persistent symptoms related to SARS-CoV-2 infection? ☐ Yes (complete the section 2) ☐ No (go to next)

Has the participant had any new disease and/or worsening and/or deterioration of a pre-existing disease? ☐ Yes (complete the section 4) ☐ No (go to next)

SECTION 2 : Current symptoms

Joint pain (Arthralgia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Confusion / altered mental status?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Red eye (Conjunctivitis)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abdominal pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath (Dyspnea)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Extremity weakness or numbness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever ($\geq 38.0^{\circ}\text{C}$)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemoptysis / Bloody sputum?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headache?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle aches (Myalgia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea / vomiting ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Leg swelling (Edema) ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of taste / lost of smell?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Skin rash?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Runny nose (Rhinorrhea)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheezing or stridor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble speaking (Aphasia / Dysphasia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Functional status

Circle the correct answers

Mobility	1. I have no problems in walking about 2. I have slight problems in walking about 3. I have moderate problems in walking about 4. I have severe problems in walking about 5, I am unable to walk about
Self-care	1. I have no problem washing or dressing myself 2. I have slight problems washing or dressing myself 3. I have moderate problems washing or dressing myself 4. I have severe problems washing or dressing myself 5. am unable to wash or dress myself
Usual activities (i.e. work, study, housework, family or leisure activities)	1. I have no problems doing my usual activities 2. I have slight problems doing my usual activities 3. I have moderate problems doing my usual activities 4. I have severe problems doing my usual activities 5. I am unable to do my usual activities
Pain and discomfort	1. I have no pain or discomfort 2. I have slight pain or discomfort 3. I have moderate pain or discomfort 4. I have severe pain or discomfort 5. I have extreme pain or discomfort
Anxiety and depression	1. I am not anxious or depressed 2. I am slightly anxious or depressed 3. I am moderately anxious or depressed 4. I am severely anxious or depressed 5. I am extremely anxious or depressed
Breathlessness	1. I am breathless only with strenuous exercise 2. I am short of breath when hurrying or going up a slight hill 3. I am slower than most people of the same age on level ground 4. I stop for breath walking 100m or few minutes on level ground 5. I am too breathless to leave the house
Rate your health from 0 (worst) to 100 (best)	0 (worst / pire) 100 (best / meilleur) _____ %
How much difficulty do you have lifting or carrying 10 lbs?	1. Noe 2. Some 3. A lot or unable

How much difficulty do you have walking across a room?	1. Noe 2. Some 3. A lot or unable
How much difficulty do you have transferring from a chair to a bed?	1. Noe 2. Some 3. A lot or unable
How much difficulty do you have climbing a flight of 10 stairs?	1, Noe 2, Some 3, A lot or unable
How many times have you fallen in the past year?	0. Noe 1. 1-3 falls 2. 4 or more falls

EuroQol Group. (2011). EQ-5D-5L User Guide. Rotterdam: EuroQol Group. Available at <http://www.euroqol.org/eq-5d/publications/user-guide.html>; Nerys Williams, The MRC breathlessness scale, Occupational Medicine, 2017; 67(6): 496-497; Malmstrom TK, Morley JE. SARC-F: a simple questionnaire to rapidly diagnose sarcopenia. J Am Med Dir Assoc. 2013;14(8):531-532.

SECTION 4 : Complications Post-COVID

Cardiovascular complications?

- ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection

- ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Cardiac arrest?	<input type="checkbox"/>	<input type="checkbox"/>
Other cardiac arrhythmia?	<input type="checkbox"/>	<input type="checkbox"/>
Endocarditis? Myocarditis? Pericarditis?	<input type="checkbox"/>	<input type="checkbox"/>
New atrial fibrillation or flutter (FA)?	<input type="checkbox"/>	<input type="checkbox"/>
Ventricular tachycardia or fibrillation (VT/VF)?	<input type="checkbox"/>	<input type="checkbox"/>
Left ventricular fonction?	<input type="checkbox"/>	<input type="checkbox"/>
Decompensated heart failure??	<input type="checkbox"/>	<input type="checkbox"/>
Non-ST-elevation myocardial infarction (NSTEMI)? ST-elevation myocardial infarction (STEMI)?	<input type="checkbox"/>	<input type="checkbox"/>
Deep vein thrombosis (DVT)?	<input type="checkbox"/>	<input type="checkbox"/>
Dissiminated intravascular coagulation?	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory complications?

- ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection

- ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Bronchiolitis?	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary embolism (PE)?	<input type="checkbox"/>	<input type="checkbox"/>
Pleural effusion?	<input type="checkbox"/>	<input type="checkbox"/>
Interstitial lung disease?	<input type="checkbox"/>	<input type="checkbox"/>
COPD?	<input type="checkbox"/>	<input type="checkbox"/>
Bacterial, viral or cryptogenic organizing pneumonia?	<input type="checkbox"/>	<input type="checkbox"/>
Pneumothorax?	<input type="checkbox"/>	<input type="checkbox"/>
Acute Respiratory Distress Syndrome (ARDS)?	<input type="checkbox"/>	<input type="checkbox"/>

Renal complications? ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Acute kidney injury?	<input type="checkbox"/>	<input type="checkbox"/>

Neurologic complications? ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
TIA? Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Seizure?	<input type="checkbox"/>	<input type="checkbox"/>
Méningitis / encephalitis?	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with concentration?	<input type="checkbox"/>	<input type="checkbox"/>
Memory problem? Brain Fog?	<input type="checkbox"/>	<input type="checkbox"/>

Psychiatric complications? ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Depression?	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety?	<input type="checkbox"/>	<input type="checkbox"/>
Mood change?	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal complications?	<input type="checkbox"/> Yes (complete the section) <input type="checkbox"/> No (go to next)												
Connection with SARS-CoV-2 infection	<input type="checkbox"/> Recently appeared and directly linked to COVID-19 episode <input type="checkbox"/> Pathology already present but worsening / deterioration <input type="checkbox"/> Note related to SARS-CoV-2 infection <input type="checkbox"/> Undetermined												
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Gastrointestinal heamorrhage?	<input type="checkbox"/>	<input type="checkbox"/>											
Pancreatitis?	<input type="checkbox"/>	<input type="checkbox"/>											

Complications of the endocrine system?	<input type="checkbox"/> Yes (complete the section) <input type="checkbox"/> No (go to next)									
Connection with SARS-CoV-2 infection	<input type="checkbox"/> Recently appeared and directly linked to COVID-19 episode <input type="checkbox"/> Pathology already present but worsening / deterioration <input type="checkbox"/> Note related to SARS-CoV-2 infection <input type="checkbox"/> Undetermined									
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	No	Yes								
Hyperglycemia?	<input type="checkbox"/>	<input type="checkbox"/>								
Hypoglycemia?	<input type="checkbox"/>	<input type="checkbox"/>								

Others complications?	<input type="checkbox"/> Yes (complete the section) <input type="checkbox"/> No (go to next)																					
Connection with SARS-CoV-2 infection	<input type="checkbox"/> Recently appeared and directly linked to COVID-19 episode <input type="checkbox"/> Pathology already present but worsening / deterioration <input type="checkbox"/> Note related to SARS-CoV-2 infection <input type="checkbox"/> Undetermined																					
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Rhabdomyolysis or myositis?	<input type="checkbox"/>	<input type="checkbox"/>																				
Others	<input type="checkbox"/>	<input type="checkbox"/>																				

SECTION 5 : Tests

Medical context of the requested follow-up examinations

Cardiac assessment

Coronary angiography (Cardiac catheterization)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Point of care ultrasound (POCUS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Echocardiogram?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Electrocardiogram (EKG)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Percutaneous coronary intervention ("stented")?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical imaging	
Chest X-ray?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT Abdomen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT Thorax?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT Head?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other imaging test(s)?	
Respiratory function tests	
Spirometry?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Metacholine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung function test?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 6 : Labs Follow up

OPTIONAL - To be completed if the participant had routine laboratories as part of their follow-up. These tests are MANDATORY.

IgG			
Total WBC count	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured
Neutrophil count	_____	%	<input type="checkbox"/> Not measured
Lymphocyte count	_____	%	<input type="checkbox"/> Not measured
Monocyte count	_____	%	<input type="checkbox"/> Not measured
Eosinophil count	_____	%	<input type="checkbox"/> Not measured
Basophil count	_____	%	<input type="checkbox"/> Not measured
Platelets	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured
Haemoglobin	_____	g/L	<input type="checkbox"/> Not measured
Urea	_____	mmol/L	<input type="checkbox"/> Not measured
Creatinine	_____	µmol/L	<input type="checkbox"/> Not measured
NT-proBNP	_____	ng/L	<input type="checkbox"/> Not measured
BNP	_____	ng/L	<input type="checkbox"/> Not measured
Sodium Na+	_____	mmol/L	<input type="checkbox"/> Not measured
Potassium K+	_____	mmol/L	<input type="checkbox"/> Not measured
C-reactive protein (CRP)	_____	mg/L	<input type="checkbox"/> Not measured
LDH	_____	U/L	<input type="checkbox"/> Not measured
Creatine Phosphokinase (CPK)	_____	U/L	<input type="checkbox"/> Not measured
Albumin	_____	g/L	<input type="checkbox"/> Not measured

AST	_____	U/L	<input type="checkbox"/> Not measured
ALT	_____	U/L	<input type="checkbox"/> Not measured
Procalcitonin (PCT)	_____	µg/L	<input type="checkbox"/> Not measured
Troponin T hs (high sensitivity)	_____	ng/L	<input type="checkbox"/> Not measured
Troponin I hs (high sensitivity)	_____	ng/L	<input type="checkbox"/> Not measured
Troponin T	_____	ng/L	<input type="checkbox"/> Not measured
Troponin I	_____	ng/L	<input type="checkbox"/> Not measured
APTT (activated partial thromboplastin time)	_____	sec	<input type="checkbox"/> Not measured
International Normalized Ratio (INR)	_____		<input type="checkbox"/> Not measured
Triglycerides	_____	mmol/L	<input type="checkbox"/> Not measured
Total bilirubin	_____	µmol/L	<input type="checkbox"/> Not measured
Direct bilirubin (conjugated)	_____	µmol/L	<input type="checkbox"/> Not measured
Glucose	_____	mmol/L	<input type="checkbox"/> Not measured
Fibrinogen	_____	g/L	<input type="checkbox"/> Not measured
Ferritin	_____	µg/L	<input type="checkbox"/> Not measured
IL-6	_____	ng/L	<input type="checkbox"/> Not measured
CD4	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured
CD8	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured

SECTION 7 : Clinical frailty score

Frailty scale (clinical frailty scale) (circle) 1 2 3 4 5 6 7 8 9 ☐ n/d

Clinical Frailty Scale*



1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.



2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.



3 Managing Well – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.



4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up", and/or being tired during the day.



5 Mildly Frail – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.



6 Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.



7 Severely Frail – Completely dependent for **personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).



8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.



9. Terminally Ill – Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rodwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173:489-495.

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FOLLOW-UP VISIT 540 DAYS

Visit Description

Blood drawn for the BQC19? ☐ Yes (go to section 1) ☐ No (go to section 2)

SECTION 1 : Samples taken for BQC19

Date of blood draw (aaaa-mm-dd) _____

Time of blood draw (hh:mm) _____

Delay between the diagnosis and the draw blood Automatic calculation in REDCap (do not complete)

- Collected :
- ☐ Ambulatory emergency
 - ☐ Emergency stretchers
 - ☐ Intensive Care Unit
 - ☐ Outpatient clinic
 - ☐ Hospital floor (specify) : _____
 - ☐ Other (specify) : _____

SECTION 2 : No samples taken for BQC19

If no blood sample was taken for BQC19, when was the clinical data collected? (yyyy-mm-dd)? _____

Why not collected? _____

BQC19 Samples

Number of ACD tubes collected: _____

Number of PAXgene tubes collected: _____

Number of serum tubes collected: _____

Other blood draw tube(s) collected: _____

PEDIATRIC - stool collected: ☐ Yes ☐ No ☐ N/A

Were other biological samples collected? ☐ Yes ☐ No

Other sample #1 _____ Quantity : _____

Other sample #2 _____ Quantity : _____

Other sample #3 _____ Quantity : _____

Essential Follow-up

Was this follow-up visit completed?

☐ Yes ☐ No

Date of follow-up (yyyy-mm-dd) : _____

Delay between the diagnosis and the follow-up visit

Automatic calculation in REDCap (do not complete)

How was this follow-up completed?

☐ By phone

☐ In person

Who answered the questions?

Check all that apply.

☐ Patient

☐ Surrogate

☐ Health-care professional

Name of interviewer _____

SECTION 1 : Ongoing Consent

Ongoing consent status:

☐ Withdrawal from the study

☐ Partial withdrawal - consent to blood draws only

☐ Partial withdrawal - consent to follow-up only

☐ Consent to all study procedures

SECTION 2 : Vital Status Update

Date of last known vital status (yyyy-mm-dd) : _____

Vital status
☐ Alive

☐ Deceased

☐ Unknown

Follow up

Have you been diagnosed with a new or recurrent case of COVID since your last follow-up (based on PCR testing)?

☐ Yes (If the participant has had a new positive VIDOC test - please complete the End of Participation form and start a new BQC19 registration for this patient).

☐ No

Have you been re-hospitalized since your initial visit for COVID, excluding outpatient clinic visits and planned follow-up visits?

☐ Yes (go to section 1)

☐ No (go to section 2)

SECTION 1 : Medical follow-up

Have you been re-hospitalized since your initial visit for COVID-19, excluding outpatient clinic visit and planned follow-up visit? (If multiple re-hospitalization, enter the most significant one and describe the other ones in the additional comments fields at the end of the form)

☐ Yes ☐ No

Type of repeat hospital visit?

Check all that apply.

☐ Emergency room visit

☐ Hospital admission

☐ Not sure

If emergency or re-hospitalization, date of admission (yyyy-mm-dd) : _____

Facility: _____

Cause : _____

Were additional medical examinations requested as part of this follow-up? (OPTIONAL – For clinical purpose) ☐ Yes (complete the section 5) ☐ No (go to next)

Have laboratory tests been done for this day? (OPTIONAL – For clinical purpose) ☐ Yes (complete the section 6) ☐ No (go to next)

Does the participant report persistent symptoms related to SARS-CoV-2 infection? ☐ Yes (complete the section 2) ☐ No (go to next)

Has the participant had any new disease and/or worsening and/or deterioration of a pre-existing disease? ☐ Yes (complete the section 4) ☐ No (go to next)

SECTION 2 : Current symptoms

Joint pain (Arthralgia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Confusion / altered mental status?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Red eye (Conjunctivitis)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abdominal pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath (Dyspnea)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Extremity weakness or numbness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever ($\geq 38.0^{\circ}\text{C}$)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemoptysis / Bloody sputum?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headache?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle aches (Myalgia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea / vomiting ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Leg swelling (Edema) ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of taste / lost of smell?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Skin rash?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Runny nose (Rhinorrhea)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheezing or stridor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble speaking (Aphasia / Dysphasia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Functional status

Circle the correct answers

Mobility	1. I have no problems in walking about 2. I have slight problems in walking about 3. I have moderate problems in walking about 4. I have severe problems in walking about 5, I am unable to walk about
Self-care	1. I have no problem washing or dressing myself 2. I have slight problems washing or dressing myself 3. I have moderate problems washing or dressing myself 4. I have severe problems washing or dressing myself 5. am unable to wash or dress myself
Usual activities (i.e. work, study, housework, family or leisure activities)	1. I have no problems doing my usual activities 2. I have slight problems doing my usual activities 3. I have moderate problems doing my usual activities 4. I have severe problems doing my usual activities 5. I am unable to do my usual activities
Pain and discomfort	1. I have no pain or discomfort 2. I have slight pain or discomfort 3. I have moderate pain or discomfort 4. I have severe pain or discomfort 5. I have extreme pain or discomfort
Anxiety and depression	1. I am not anxious or depressed 2. I am slightly anxious or depressed 3. I am moderately anxious or depressed 4. I am severely anxious or depressed 5. I am extremely anxious or depressed
Breathlessness	1. I am breathless only with strenuous exercise 2. I am short of breath when hurrying or going up a slight hill 3. I am slower than most people of the same age on level ground 4. I stop for breath walking 100m or few minutes on level ground 5. I am too breathless to leave the house
Rate your health from 0 (worst) to 100 (best)	0 (worst / pire) 100 (best / meilleur) _____ %
How much difficulty do you have lifting or carrying 10 lbs?	1. Noe 2. Some 3. A lot or unable

How much difficulty do you have walking across a room?	1. Noe 2. Some 3. A lot or unable
How much difficulty do you have transferring from a chair to a bed?	1. Noe 2. Some 3. A lot or unable
How much difficulty do you have climbing a flight of 10 stairs?	1, Noe 2, Some 3, A lot or unable
How many times have you fallen in the past year?	0. Noe 1. 1-3 falls 2. 4 or more falls

EuroQol Group. (2011). EQ-5D-5L User Guide. Rotterdam: EuroQol Group. Available at <http://www.euroqol.org/eq-5d/publications/user-guide.html>; Nerys Williams, The MRC breathlessness scale, Occupational Medicine, 2017; 67(6): 496-497; Malmstrom TK, Morley JE. SARC-F: a simple questionnaire to rapidly diagnose sarcopenia. J Am Med Dir Assoc. 2013;14(8):531-532.

SECTION 4 : Complications Post-COVID

Cardiovascular complications?

- ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection

- ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Cardiac arrest?	<input type="checkbox"/>	<input type="checkbox"/>
Other cardiac arrhythmia?	<input type="checkbox"/>	<input type="checkbox"/>
Endocarditis? Myocarditis? Pericarditis?	<input type="checkbox"/>	<input type="checkbox"/>
New atrial fibrillation or flutter (FA)?	<input type="checkbox"/>	<input type="checkbox"/>
Ventricular tachycardia or fibrillation (VT/VF)?	<input type="checkbox"/>	<input type="checkbox"/>
Left ventricular fonction?	<input type="checkbox"/>	<input type="checkbox"/>
Decompensated heart failure??	<input type="checkbox"/>	<input type="checkbox"/>
Non-ST-elevation myocardial infarction (NSTEMI)? ST-elevation myocardial infarction (STEMI)?	<input type="checkbox"/>	<input type="checkbox"/>
Deep vein thrombosis (DVT)?	<input type="checkbox"/>	<input type="checkbox"/>
Dissiminated intravascular coagulation?	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory complications?

- ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection

- ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Bronchiolitis?	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary embolism (PE)?	<input type="checkbox"/>	<input type="checkbox"/>
Pleural effusion?	<input type="checkbox"/>	<input type="checkbox"/>
Interstitial lung disease?	<input type="checkbox"/>	<input type="checkbox"/>
COPD?	<input type="checkbox"/>	<input type="checkbox"/>
Bacterial, viral or cryptogenic organizing pneumonia?	<input type="checkbox"/>	<input type="checkbox"/>
Pneumothorax?	<input type="checkbox"/>	<input type="checkbox"/>
Acute Respiratory Distress Syndrome (ARDS)?	<input type="checkbox"/>	<input type="checkbox"/>

Renal complications? ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Acute kidney injury?	<input type="checkbox"/>	<input type="checkbox"/>

Neurologic complications? ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
TIA? Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Seizure?	<input type="checkbox"/>	<input type="checkbox"/>
Méningitis / encephalitis?	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with concentration?	<input type="checkbox"/>	<input type="checkbox"/>
Memory problem? Brain Fog?	<input type="checkbox"/>	<input type="checkbox"/>

Psychiatric complications? ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Depression?	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety?	<input type="checkbox"/>	<input type="checkbox"/>
Mood change?	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal complications?		<input type="checkbox"/> Yes (complete the section)
		<input type="checkbox"/> No (go to next)
Connection with SARS-CoV-2 infection	<input type="checkbox"/> Recently appeared and directly linked to COVID-19 episode <input type="checkbox"/> Pathology already present but worsening / deterioration <input type="checkbox"/> Note related to SARS-CoV-2 infection <input type="checkbox"/> Undetermined	
	No	Yes
Liver dysfunction?	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal heamorrhage?	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatitis?	<input type="checkbox"/>	<input type="checkbox"/>

Complications of the endocrine system?		<input type="checkbox"/> Yes (complete the section)
		<input type="checkbox"/> No (go to next)
Connection with SARS-CoV-2 infection	<input type="checkbox"/> Recently appeared and directly linked to COVID-19 episode <input type="checkbox"/> Pathology already present but worsening / deterioration <input type="checkbox"/> Note related to SARS-CoV-2 infection <input type="checkbox"/> Undetermined	
	No	Yes
Hyperglycemia?	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia?	<input type="checkbox"/>	<input type="checkbox"/>

Others complications?		<input type="checkbox"/> Yes (complete the section)
		<input type="checkbox"/> No (go to next)
Connection with SARS-CoV-2 infection	<input type="checkbox"/> Recently appeared and directly linked to COVID-19 episode <input type="checkbox"/> Pathology already present but worsening / deterioration <input type="checkbox"/> Note related to SARS-CoV-2 infection <input type="checkbox"/> Undetermined	
	No	Yes
Anemia?	<input type="checkbox"/>	<input type="checkbox"/>
Bacteriemia?	<input type="checkbox"/>	<input type="checkbox"/>
Rhabdomyolysis or myositis?	<input type="checkbox"/>	<input type="checkbox"/>
Others	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 5 : Tests

Medical context of the requested follow-up examinations

Cardiac assessment

Coronary angiography (Cardiac catheterization)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Point of care ultrasound (POCUS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Echocardiogram?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Electrocardiogram (EKG)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Percutaneous coronary intervention ("stented")?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical imaging	
Chest X-ray?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT Abdomen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT Thorax?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT Head?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other imaging test(s)?	
Respiratory function tests	
Spirometry?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Metacholine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung function test?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 6 : Labs Follow up

OPTIONAL - To be completed if the participant had routine laboratories as part of their follow-up. These tests are MANDATORY.

IgG			
Total WBC count	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured
Neutrophil count	_____	%	<input type="checkbox"/> Not measured
Lymphocyte count	_____	%	<input type="checkbox"/> Not measured
Monocyte count	_____	%	<input type="checkbox"/> Not measured
Eosinophil count	_____	%	<input type="checkbox"/> Not measured
Basophil count	_____	%	<input type="checkbox"/> Not measured
Platelets	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured
Haemoglobin	_____	g/L	<input type="checkbox"/> Not measured
Urea	_____	mmol/L	<input type="checkbox"/> Not measured
Creatinine	_____	µmol/L	<input type="checkbox"/> Not measured
NT-proBNP	_____	ng/L	<input type="checkbox"/> Not measured
BNP	_____	ng/L	<input type="checkbox"/> Not measured
Sodium Na+	_____	mmol/L	<input type="checkbox"/> Not measured
Potassium K+	_____	mmol/L	<input type="checkbox"/> Not measured
C-reactive protein (CRP)	_____	mg/L	<input type="checkbox"/> Not measured
LDH	_____	U/L	<input type="checkbox"/> Not measured
Creatine Phosphokinase (CPK)	_____	U/L	<input type="checkbox"/> Not measured
Albumin	_____	g/L	<input type="checkbox"/> Not measured

AST	_____	U/L	<input type="checkbox"/> Not measured
ALT	_____	U/L	<input type="checkbox"/> Not measured
Procalcitonin (PCT)	_____	µg/L	<input type="checkbox"/> Not measured
Troponin T hs (high sensitivity)	_____	ng/L	<input type="checkbox"/> Not measured
Troponin I hs (high sensitivity)	_____	ng/L	<input type="checkbox"/> Not measured
Troponin T	_____	ng/L	<input type="checkbox"/> Not measured
Troponin I	_____	ng/L	<input type="checkbox"/> Not measured
APTT (activated partial thromboplastin time)	_____	sec	<input type="checkbox"/> Not measured
International Normalized Ratio (INR)	_____		<input type="checkbox"/> Not measured
Triglycerides	_____	mmol/L	<input type="checkbox"/> Not measured
Total bilirubin	_____	µmol/L	<input type="checkbox"/> Not measured
Direct bilirubin (conjugated)	_____	µmol/L	<input type="checkbox"/> Not measured
Glucose	_____	mmol/L	<input type="checkbox"/> Not measured
Fibrinogen	_____	g/L	<input type="checkbox"/> Not measured
Ferritin	_____	µg/L	<input type="checkbox"/> Not measured
IL-6	_____	ng/L	<input type="checkbox"/> Not measured
CD4	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured
CD8	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured

SECTION 7 : Clinical frailty score

Frailty scale (clinical frailty scale) (circle) 1 2 3 4 5 6 7 8 9 ☐ n/d

Clinical Frailty Scale*



1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.



2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.



3 Managing Well – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.



4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up", and/or being tired during the day.



5 Mildly Frail – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.



6 Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.



7 Severely Frail – Completely dependent for **personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).



8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.



9. Terminally Ill – Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rodwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173:489-495.

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FOLLOW-UP VISIT 730 DAYS

Visit Description

Blood drawn for the BQC19? ☐ Yes (go to section 1) ☐ No (go to section 2)

SECTION 1 : Samples taken for BQC19

Date of blood draw (aaaa-mm-dd) _____

Time of blood draw (hh:mm) _____

Delay between the diagnosis and the draw blood _____ Automatic calculation in REDCap (do not complete)

Collected : ☐ Ambulatory emergency
☐ Emergency stretchers
☐ Intensive Care Unit
☐ Outpatient clinic
☐ Hospital floor (specify) : _____
☐ Other (specify) : _____

SECTION 2 : No samples taken for BQC19

If no blood sample was taken for BQC19, when was the clinical data collected? (yyyy-mm-dd)? _____

Why not collected? _____

BQC19 Samples

Number of ACD tubes collected: _____

Number of PAXgene tubes collected: _____

Number of serum tubes collected: _____

Other blood draw tube(s) collected: _____

PEDIATRIC - stool collected: ☐ Yes ☐ No ☐ N/A

Were other biological samples collected? ☐ Yes ☐ No

Other sample #1 _____ Quantity : _____

Other sample #2 _____ Quantity : _____

Other sample #3 _____ Quantity : _____

Essential Follow-up

Was this follow-up visit completed?

☐ Yes ☐ No

Date of follow-up (yyyy-mm-dd) : _____

Delay between the diagnosis and the follow-up visit

Automatic calculation in REDCap (do not complete)

How was this follow-up completed?

☐ By phone

☐ In person

Who answered the questions?

Check all that apply.

☐ Patient

☐ Surrogate

☐ Health-care professional

Name of interviewer _____

SECTION 1 : Ongoing Consent

Ongoing consent status:

☐ Withdrawal from the study

☐ Partial withdrawal - consent to blood draws only

☐ Partial withdrawal - consent to follow-up only

☐ Consent to all study procedures

SECTION 2 : Vital Status Update

Date of last known vital status (yyyy-mm-dd) : _____

Vital status
☐ Alive

☐ Deceased

☐ Unknown

Follow up

Have you been diagnosed with a new or recurrent case of COVID since your last follow-up (based on PCR testing)?

☐ Yes (If the participant has had a new positive VIDOC test - please complete the End of Participation form and start a new BQC19 registration for this patient).

☐ No

Have you been re-hospitalized since your initial visit for COVID, excluding outpatient clinic visits and planned follow-up visits?

☐ Yes (go to section 1)

☐ No (go to section 2)

SECTION 1 : Medical follow-up

Have you been re-hospitalized since your initial visit for COVID-19, excluding outpatient clinic visit and planned follow-up visit? (If multiple re-hospitalization, enter the most significant one and describe the other ones in the additional comments fields at the end of the form)

☐ Yes ☐ No

Type of repeat hospital visit?

Check all that apply.

☐ Emergency room visit

☐ Hospital admission

☐ Not sure

If emergency or re-hospitalization, date of admission (yyyy-mm-dd) : _____

Facility: _____

Cause : _____

Were additional medical examinations requested as part of this follow-up? (OPTIONAL – For clinical purpose) ☐ Yes (complete the section 5) ☐ No (go to next)

Have laboratory tests been done for this day? (OPTIONAL – For clinical purpose) ☐ Yes (complete the section 6) ☐ No (go to next)

Does the participant report persistent symptoms related to SARS-CoV-2 infection? ☐ Yes (complete the section 2) ☐ No (go to next)

Has the participant had any new disease and/or worsening and/or deterioration of a pre-existing disease? ☐ Yes (complete the section 4) ☐ No (go to next)

SECTION 2 : Current symptoms

Joint pain (Arthralgia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Confusion / altered mental status?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Red eye (Conjunctivitis)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abdominal pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath (Dyspnea)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Extremity weakness or numbness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever ($\geq 38.0^{\circ}\text{C}$)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemoptysis / Bloody sputum?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headache?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle aches (Myalgia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea / vomiting ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Leg swelling (Edema) ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of taste / lost of smell?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Skin rash?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Runny nose (Rhinorrhea)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheezing or stridor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble speaking (Aphasia / Dysphasia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Functional status

Circle the correct answers

Mobility	1. I have no problems in walking about 2. I have slight problems in walking about 3. I have moderate problems in walking about 4. I have severe problems in walking about 5, I am unable to walk about
Self-care	1. I have no problem washing or dressing myself 2. I have slight problems washing or dressing myself 3. I have moderate problems washing or dressing myself 4. I have severe problems washing or dressing myself 5. am unable to wash or dress myself
Usual activities (i.e. work, study, housework, family or leisure activities)	1. I have no problems doing my usual activities 2. I have slight problems doing my usual activities 3. I have moderate problems doing my usual activities 4. I have severe problems doing my usual activities 5. I am unable to do my usual activities
Pain and discomfort	1. I have no pain or discomfort 2. I have slight pain or discomfort 3. I have moderate pain or discomfort 4. I have severe pain or discomfort 5. I have extreme pain or discomfort
Anxiety and depression	1. I am not anxious or depressed 2. I am slightly anxious or depressed 3. I am moderately anxious or depressed 4. I am severely anxious or depressed 5. I am extremely anxious or depressed
Breathlessness	1. I am breathless only with strenuous exercise 2. I am short of breath when hurrying or going up a slight hill 3. I am slower than most people of the same age on level ground 4. I stop for breath walking 100m or few minutes on level ground 5. I am too breathless to leave the house
Rate your health from 0 (worst) to 100 (best)	0 (worst / pire) 100 (best / meilleur) _____ %
How much difficulty do you have lifting or carrying 10 lbs?	1. Noe 2. Some 3. A lot or unable

How much difficulty do you have walking across a room?	1. Noe 2. Some 3. A lot or unable
How much difficulty do you have transferring from a chair to a bed?	1. Noe 2. Some 3. A lot or unable
How much difficulty do you have climbing a flight of 10 stairs?	1, Noe 2, Some 3, A lot or unable
How many times have you fallen in the past year?	0. Noe 1. 1-3 falls 2. 4 or more falls

EuroQol Group. (2011). EQ-5D-5L User Guide. Rotterdam: EuroQol Group. Available at <http://www.euroqol.org/eq-5d/publications/user-guide.html>; Nerys Williams, The MRC breathlessness scale, Occupational Medicine, 2017; 67(6): 496-497; Malmstrom TK, Morley JE. SARC-F: a simple questionnaire to rapidly diagnose sarcopenia. J Am Med Dir Assoc. 2013;14(8):531-532.

SECTION 4 : Complications Post-COVID

Cardiovascular complications?

- ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection

- ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Cardiac arrest?	<input type="checkbox"/>	<input type="checkbox"/>
Other cardiac arrhythmia?	<input type="checkbox"/>	<input type="checkbox"/>
Endocarditis? Myocarditis? Pericarditis?	<input type="checkbox"/>	<input type="checkbox"/>
New atrial fibrillation or flutter (FA)?	<input type="checkbox"/>	<input type="checkbox"/>
Ventricular tachycardia or fibrillation (VT/VF)?	<input type="checkbox"/>	<input type="checkbox"/>
Left ventricular fonction?	<input type="checkbox"/>	<input type="checkbox"/>
Decompensated heart failure??	<input type="checkbox"/>	<input type="checkbox"/>
Non-ST-elevation myocardial infarction (NSTEMI)? ST-elevation myocardial infarction (STEMI)?	<input type="checkbox"/>	<input type="checkbox"/>
Deep vein thrombosis (DVT)?	<input type="checkbox"/>	<input type="checkbox"/>
Dissiminated intravascular coagulation?	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory complications?

- ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection

- ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Bronchiolitis?	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary embolism (PE)?	<input type="checkbox"/>	<input type="checkbox"/>
Pleural effusion?	<input type="checkbox"/>	<input type="checkbox"/>
Interstitial lung disease?	<input type="checkbox"/>	<input type="checkbox"/>
COPD?	<input type="checkbox"/>	<input type="checkbox"/>
Bacterial, viral or cryptogenic organizing pneumonia?	<input type="checkbox"/>	<input type="checkbox"/>
Pneumothorax?	<input type="checkbox"/>	<input type="checkbox"/>
Acute Respiratory Distress Syndrome (ARDS)?	<input type="checkbox"/>	<input type="checkbox"/>

Renal complications? ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Acute kidney injury?	<input type="checkbox"/>	<input type="checkbox"/>

Neurologic complications? ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
TIA? Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Seizure?	<input type="checkbox"/>	<input type="checkbox"/>
Méningitis / encephalitis?	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with concentration?	<input type="checkbox"/>	<input type="checkbox"/>
Memory problem? Brain Fog?	<input type="checkbox"/>	<input type="checkbox"/>

Psychiatric complications? ☐ Yes (complete the section)
☐ No (go to next)

Connection with SARS-CoV-2 infection ☐ Recently appeared and directly linked to COVID-19 episode
☐ Pathology already present but worsening / deterioration
☐ Note related to SARS-CoV-2 infection
☐ Undetermined

	No	Yes
Depression?	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety?	<input type="checkbox"/>	<input type="checkbox"/>
Mood change?	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal complications?	<input type="checkbox"/> Yes (complete the section) <input type="checkbox"/> No (go to next)												
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Complications of the endocrine system?	<input type="checkbox"/> Yes (complete the section) <input type="checkbox"/> No (go to next)									
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Others complications?	<input type="checkbox"/> Yes (complete the section) <input type="checkbox"/> No (go to next)																					
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Rhabdomyolysis or myositis?	<input type="checkbox"/>	<input type="checkbox"/>																				
Others	<input type="checkbox"/>	<input type="checkbox"/>																				

SECTION 5 : Tests

Medical context of the requested follow-up examinations

Cardiac assessment

Coronary angiography (Cardiac catheterization)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Point of care ultrasound (POCUS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Echocardiogram?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Electrocardiogram (EKG)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Percutaneous coronary intervention ("stented")?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical imaging	
Chest X-ray?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT Abdomen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT Thorax?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT Head?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other imaging test(s)?	
Respiratory function tests	
Spirometry?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Metacholine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung function test?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 6 : Labs Follow up

OPTIONAL - To be completed if the participant had routine laboratories as part of their follow-up. These tests are MANDATORY.

IgG			
Total WBC count	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured
Neutrophil count	_____	%	<input type="checkbox"/> Not measured
Lymphocyte count	_____	%	<input type="checkbox"/> Not measured
Monocyte count	_____	%	<input type="checkbox"/> Not measured
Eosinophil count	_____	%	<input type="checkbox"/> Not measured
Basophil count	_____	%	<input type="checkbox"/> Not measured
Platelets	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured
Haemoglobin	_____	g/L	<input type="checkbox"/> Not measured
Urea	_____	mmol/L	<input type="checkbox"/> Not measured
Creatinine	_____	μmol/L	<input type="checkbox"/> Not measured
NT-proBNP	_____	ng/L	<input type="checkbox"/> Not measured
BNP	_____	ng/L	<input type="checkbox"/> Not measured
Sodium Na+	_____	mmol/L	<input type="checkbox"/> Not measured
Potassium K+	_____	mmol/L	<input type="checkbox"/> Not measured
C-reactive protein (CRP)	_____	mg/L	<input type="checkbox"/> Not measured
LDH	_____	U/L	<input type="checkbox"/> Not measured
Creatine Phosphokinase (CPK)	_____	U/L	<input type="checkbox"/> Not measured
Albumin	_____	g/L	<input type="checkbox"/> Not measured

AST	_____	U/L	<input type="checkbox"/> Not measured
ALT	_____	U/L	<input type="checkbox"/> Not measured
Procalcitonin (PCT)	_____	µg/L	<input type="checkbox"/> Not measured
Troponin T hs (high sensitivity)	_____	ng/L	<input type="checkbox"/> Not measured
Troponin I hs (high sensitivity)	_____	ng/L	<input type="checkbox"/> Not measured
Troponin T	_____	ng/L	<input type="checkbox"/> Not measured
Troponin I	_____	ng/L	<input type="checkbox"/> Not measured
APTT (activated partial thromboplastin time)	_____	sec	<input type="checkbox"/> Not measured
International Normalized Ratio (INR)	_____		<input type="checkbox"/> Not measured
Triglycerides	_____	mmol/L	<input type="checkbox"/> Not measured
Total bilirubin	_____	µmol/L	<input type="checkbox"/> Not measured
Direct bilirubin (conjugated)	_____	µmol/L	<input type="checkbox"/> Not measured
Glucose	_____	mmol/L	<input type="checkbox"/> Not measured
Fibrinogen	_____	g/L	<input type="checkbox"/> Not measured
Ferritin	_____	µg/L	<input type="checkbox"/> Not measured
IL-6	_____	ng/L	<input type="checkbox"/> Not measured
CD4	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured
CD8	_____	x 10 ⁹ /L	<input type="checkbox"/> Not measured

SECTION 7 : Clinical frailty score

Frailty scale (clinical frailty scale) (circle) 1 2 3 4 5 6 7 8 9 ☐ n/d

Clinical Frailty Scale*



1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.



2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.



3 Managing Well – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.



4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up", and/or being tired during the day.



5 Mildly Frail – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.



6 Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.



7 Severely Frail – Completely dependent for **personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).



8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.



9. Terminally Ill - Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rodwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173:489-495.

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END-OF-STUDY VISIT

SECTION 1: Vaccination (anytime)

Has the participant been vaccinated? ☐ Yes ☐ No

From which company did the participant receive the vaccine? _____
Pfizer, Moderna, Medicago, AstraZeneca, ...

Number of doses received? ☐ 1 ☐ 2

Date first dose received (yyyy-mm-dd) _____

Date second dose received (yyyy-mm-dd) _____

Did the participant experience any side effects? ☐ Yes ☐ No

Please describe the side effects. _____

Date of study exit (yyyy-mm-dd) : _____

Reason for study exit :

- ☐ Patient deceased
- ☐ Withdrawal of consent
- ☐ Loss to follow up
- ☐ New positive PCR test for COVID
- ☐ Study completed
- ☐ Other

Please elaborate: _____

SECTION 1 : Protocol deviations/violations (this section to be filled in by a study coordinator)

Were there any protocol deviations/violations? ☐ Yes ☐ No

Have all protocol deviations/violations been appropriately documented? ☐ Yes ☐ No

General comments : _____

