**COVID-19 CRF**

**To be completed at every visit**

Require this CRF to be completed for all Caregivers and Children for all visits (enrollment, quarterly calls & follow-up in-person).

**Add Stem Question** for all Quarterly Calls and Follow-up Visits:

*“Since the last FLOURISH visit:”*

1. Have you been tested for COVID-19 Yes No Tried, but could not get tested Unknown
   1. If ‘Yes’ to Q1, continue to Q2, otherwise skip to Q8
2. Date of the test: DD/MM/YYY
   1. This date cannot be the same date of the last FLOURISH visit
3. Is this test estimated? Yes No
4. What was the reason for testing? Pre-Traveling screening Routine testing Contact tracing Other (specify)
5. What was the result of the test Positive Negative Pending Unknown
6. If your results were positive, where were you isolated? Home Hospital Clinic Other (specify)
   1. Allow free text if ‘other’ is selected
7. Have you experienced any of the following signs and symptoms when on isolation  Abdominal pain  Chest pain  Chills  Cough (new onset)  Diarrhea  Fever >37.5 °C Muscle aches Nasal Congestion Nausea/vomiting shortness of breath Sore throat
   1. Allow multiple answers to be selected
8. Has anyone in your household tested positive for COVID-19 Yes No Unknown
   1. If Yes to Q5 continue to Q6, otherwise skip to
9. Date of the test for member of household: DD/MM/YYY
10. Is this test estimated? Yes No
11. Have you been in close contact with anyone outside of your household who tested positive for COVID-19 Yes No Unknown
12. In the last 14 days, have you experienced any of the following symptoms  Abdominal pain  Chest pain  Chills  Cough (new onset)  Diarrhea  Fever >37.5 °C Muscle aches Nasal Congestion Nausea/vomiting shortness of breath Sore throat
    1. Allow multiple answers to be selected