**COVID-19 CRF**

**To be completed at every visit**

**\*Follow-up visits to have stem questions and prefilled data – See specifics below**

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:”*

***Note to Clinic staff****: This stem question language is to only capture tests, symptoms, and household member tests between the previous FLOURISH visit contact when the COVID-19 CRF was completed through THIS visit (the current quarterly call or follow up 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
   2. Q2 required if Q1 is “Yes”
3. Is this test estimated? Yes No
   1. Q3 is required if a Q1 is answered ‘Yes’
4. What was the reason for testing? None Pre-Traveling screening Routine testing Contact tracing Other (specify)
5. What was the result of the test None Positive Negative Pending Unknown
6. If your results were positive, where were you isolated? None Home Hospital Clinic Other (specify)
   1. Allow free text if ‘other’ is selected
   2. Q6 is only required if Q5 is “Positive”
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/Runny Nose Nausea/vomiting shortness of breath Sore throat No Symptoms Headache Loss of Smell Loss of Taste
   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
   1. Q9 is required if Q8 is “Yes”
10. Have you been in close contact with anyone outside of your household who tested positive for COVID-19 Yes No Unknown
11. 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/Runny Nose Nausea/vomiting shortness of breath Sore throat No Symptoms Headache Loss of Smell Loss of Taste
    1. Allow multiple answers to be selected

**Note to DMC:** Please prefill all responses to all remaining questions (Q12 through Q15) with the responses from the previous completed COVID-19 CRF.

1. Have you been fully vaccinated for COVID-19 Yes No Partially (one jab)
   1. If ‘Yes’ or ‘Partially (one jab)’ continue to Q14
2. Which vaccine did you receive: None AstraZeneca Sinovac Pfizer Johnson & Johnson Other
   1. Allow for free text if ‘Other’ is selected
   2. If Q13 is ‘Yes’ or ‘Partially (one jab)’ Q15 is required
3. Date of first vaccine dose: \_\_\_\_\_\_\_\_\_\_\_\_DD/MM/YYY
   1. If Q13 is ‘Yes’ and if Q14 is ‘AstraZeneca’ or ‘Sinovac’ or ‘Pfizer’, Q16 is required
4. Date of the second vaccine dose: \_\_\_\_\_\_\_DD/MM/YYYY