ACUTE Follow-up on Patient's COVID-19 Status

Please contact CENTRA@asco.org if you have any problems with the data capture instruments

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Is there reason to believe that the patient's positive COVID-19 test that made them eligible for this registry was a FALSE POSITIVE?

◯ Yes
◯ No

Please confirm the previous answer: You believe this patient is not eligible due to a FALSE POSITIVE COVID-19 test result.

If you answer "Yes", the survey will end and this patient's data will be removed from the registry. Do not submit additional follow-up forms for this patient.

◯ Yes
◯ No

PATIENT HEALTH STATUS

Date of last clinical encounter with the practice for this patient: ______________________

____

The date you entered is in the future. Please revisit the date field above and revise your entry.

Has the patient died since the last clinical encounter?

◯ Yes
◯ No

What is the last date the patient was known to still be alive? ______________________

Date of death: ______________________

The patient's death was likely most related to which of the following?

◯ Cancer progression
◯ Complication of cancer treatment
◯ COVID-19 or complications due to COVID-19
◯ Another cause unrelated to Cancer or COVID-19
◯ Unknown cause of death

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Patient's ECOG performance status at clinical encounter:	◯ 0 - Fully active, able to continue with all pre-disease activities without restriction. ◯ 1 - Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work. ◯ 2 - Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours. ◯ 3 - Capable of only limited self-care. Confined to bed or chair more than 50% of waking hours. ◯ 4 - Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair. ◯ Unknown ECOG status
	__________________________________

The date you entered is in the future. Please revisit the date field above and revise your entry.

Although the patient has died, please complete the following information regarding the patient's COVID-19 experience prior to his/her death, and the next form regarding the patient's cancer status and treatment prior to his/her death.

COVID-19 INFORMATION:

Has the patient received a COVID-19 vaccine?	◯ Yes ◯ No ◯ Unsure
Do you have the date that the COVID-19 vaccine (1st injection) was obtained?	◯ Yes ◯ No
Approximately when did the patient receive the COVID-19 vaccine (1st injection)?	◯ Within the last 7 days ◯ 2 - 4 weeks ago ◯ More than 1 month ago ◯ Unsure
Date of COVID-19 vaccine (1st injection):	__________________________________
Do you have the date that the COVID-19 vaccine (2nd injection) was obtained?)	◯ Yes ◯ No
Approximately when did the patient receive the COVID-19 vaccine (2nd injection)?	◯ Within the last 7 days ◯ 2 - 4 weeks ago ◯ More than 1 month ago ◯ Unsure
Date of 2nd injection of vaccine (if received):	__________________________________
Which vaccine did the patient receive?	◯ Moderna ◯ Pfizer ◯ AstraZeneca ◯ Unsure/Unknown

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What is the patient's current (or last known) COVID-19 status?	◯ Symptomatic ◯ COVID-19 test positive but asymptomatic ◯ Fully recovered with no current symptoms ◯ Deceased due to COVID-19 or COVID-19 complication ◯ Deceased due to other or unknown cause
Given full recovery of symptoms, what is the patient's COVID-19 test status?	◯ Patient has tested negative since since resolution of symptoms ◯ Patient is COVID-19 positive despite resolution of symptoms ◯ Patient was not retested after symptom resolution (i.e. COVID-19 test status is unknown)
What COVID-19 symptoms has the patient experienced? (check all that apply)	☐ Fever ☐ Headache ☐ Sore throat ☐ Cough ☐ Shortness of breath ☐ Loss of taste or smell ☐ Vomiting ☐ Diarrhea ☐ Fatigue ☐ Body or muscle aches ☐ Loss of appetite ☐ Chest pain ☐ Congestion and/or runny nose ☐ Other ☐ None of the above (Asymptomatic)
Other COVID-19 symptoms:	______________________
Has the patient developed pneumonia?	◯ Yes ◯ No
Is the patient receiving any care or treatment (for COVID-19 or cancer) via telemedicine?	◯ Yes ◯ No ◯ Unsure
Has the patient been hospitalized for COVID-19 or COVID-19 complications?	◯ No ◯ Yes, but not in the intensive care unit ◯ Yes, in the intensive care unit
Has the patient been admitted to a temporary hospital, such as a field hospital or other building converted to hospital for the COVID-19 crisis?	◯ Yes ◯ No ◯ Unknown
Date of admission to hospital:	______________________
	______________________
The date you entered is in the future. Please revisit the date field above and revise your entry.	
Date of admission to intensive care unit:	______________________

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The date you entered is in the future. Please revisit the date field above and revise your entry.

Has the patient been discharged from the intensive care unit?
◯ Yes
◯ No

Date of discharge from the ICU: ______________________

____

The date you entered is in the future. Please revisit the date field above and revise your entry.

Has the patient been discharged from the hospital?
◯ Yes
◯ No

Date of discharge from hospital: ______________________

____

The date you entered is in the future. Please revisit the date field above and revise your entry.

What COVID-19 treatments has the patient received?

	Yes	No	Unsure or unknown
Supplemental oxygen	◯	◯	◯
Ventilator	◯	◯	◯
Anti-COVID-19 drugs	◯	◯	◯
Other treatment approaches	◯	◯	◯

What date did the patient start supplemental oxygen? ______________________

____

The date you entered is in the future. Please revisit the date field above and revise your entry.

Is the patient still on supplemental oxygen?
◯ Yes
◯ No
◯ Unsure

When did the patient stop using supplemental oxygen? ______________________

____

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The date you entered is in the future. Please revisit the date field above and revise your entry.

What date did the patient start treatment with a ventilator? ______________________

____

The date you entered is in the future. Please revisit the date field above and revise your entry.

Is the patient still on a ventilator?
- ◯ Yes
- ◯ No
- ◯ Unsure

When did the patient stop using a ventilator? ______________________

____

The date you entered is in the future. Please revisit the date field above and revise your entry.

Which anti-COVID-19 drugs has the patient received? (check all that apply)
- ☐ ribavirin
- ☐ remdesivir
- ☐ lopinavir + ritonavir (kaletra)
- ☐ avipiravir
- ☐ hydroxychloroquine
- ☐ chloroquine
- ☐ tocilizumab
- ☐ siltuximab
- ☐ azithromycin
- ☐ losartan
- ☐ convalescent plasma
- ☐ mesenchymal stem cells
- ☐ IVIG
- ☐ dexamethasone
- ☐ monoclonal antibodies
- ☐ Other
- ☐ Unknown

Other anti-COVID19 drugs: ______________________

Has the patient had any of the following SYSTEMIC complications that could be related to his/her COVID-19 illness?

	Yes	No	Unsure/Unknown
Bleeding	◯	◯	◯
Disseminated intravascular coagulation	◯	◯	◯
Multiorgan failure	◯	◯	◯

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Sepsis	◯	◯	◯

Has the patient had any of the following PULMONARY complications that could be related to his/her COVID-19 illness?

	Yes	No	Unsure/Unknown
ARDS	◯	◯	◯
Pneumonitis	◯	◯	◯
Pulmonary embolism	◯	◯	◯
Respiratory failure	◯	◯	◯

Has the patient had any of the following CARDIOVASCULAR that could be related to during his/her COVID-19 illness?

	Yes	No	Unsure/Unknown
Cardiac arrythmia	◯	◯	◯
Cerebrovascular accident (e.g., CVA, stroke)	◯	◯	◯
Congestive heart failure	◯	◯	◯
Deep venous thrombosis	◯	◯	◯
Myocardial infarction	◯	◯	◯

Has the patient had any of the following GASTROINTESTINAL complications that could be related to his/her COVID-19 illness?

	Yes	No	Unsure/Unknown
Acute hepatic injury	◯	◯	◯
Bowel perforation	◯	◯	◯
Peritonitis	◯	◯	◯

Has the patient had any of these OTHER complications that could be related to his/her COVID-19 illness?

	Yes	No	Unsure/Unknown
Acute renal failure	◯	◯	◯
Encephalopathy	◯	◯	◯
Seizures	◯	◯	◯

CLINICAL TRIAL PARTICIPATION

Has the patient received treatment for COVID-19 as part of a therapeutic clinical trial?
◯ Yes
◯ No

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