BORN ONTARIO COVID-19 REVISED CASE REPORT FORM (CRF) – JANUARY 2022

CORE DATASET: variables required for record linkage to the BIS + core variables about COVID-19

SUBMITTING ORGANIZATION:	**DATE CASE FORM COMPLETED:** dd-mm-yy

Client identifiers required for record linkage with BORN Information System (BIS)		
Last/family name(s)	Province of residence	Hospital chart number
First/given name(s)	Health card number (e.g., OHIP; RAMQ; Public Service Health Care Plan)	Midwifery Client Code (for out-of-hospital births)
Client's date of birth (DOB) dd-mm-yy	Residence postal code	Estimated date of birth (EDB)

Client SARS-CoV-2 testing (performed in pregnancy or at birth)		
CORE VARIABLES – enter Yes/No/Unknown		
Was there at least one SARS-CoV-2 **POSITIVE** PCR test?		- Leave blank if no PCR test was completed, or if it was negative
- **IF YES**, sample collection date of FIRST positive SARS-CoV-2 PCR test	dd-mm-yy	- Date of sample collection - Leave blank if no positive test / no test performed / result pending
If no PCR test was completed, was there at least one **POSITIVE** SARS-CoV-2 rapid antigen test?		- Leave blank if not applicable or if rapid antigen test was negative
- **IF YES,** collection date of positive sample	dd-mm-yy	- Leave blank if no positive test
If no testing was completed, was the individual symptomatic **AND** in close contact with an infected person		- Leave blank if not applicable - Only complete this is the individual was both symptomatic **AND** in contact with an infected person
- **IF YES**, date of suspected COVID-19 infection	dd-mm-yy	- Leave blank if not applicable
General comments		- E.g. details about reinfection (positive COVID-19 test separate from this infectious event) including date and test type

Client COVID-19 clinical symptoms observed or reported in pregnancy or at birth		
CORE VARIABLES – enter Yes/No/Unknown		
Fever (>38)	Anorexia (loss of appetite)	Loss of taste
Cough	Diarrhea	Sore throat
Shortness of breath	Vomiting	Rhinitis
Headache	Malaise	Asymptomatic
Muscle pain/myalgia	Anosmia (loss of smell)	
Other symptoms: - Leave blank if not applicable		

Client SARS-CoV-2 complications (in pregnancy or at birth)		
CORE VARIABLES		
Hospitalized for COVID-19 illness?		- Enter Yes, No or Unknown
- **IF YES**, date of hospital admission	dd-mm-yy	
- **IF YES**, date of hospital discharge	dd-mm-yy	- Date of discharge from *your* hospital
- **IF YES**, was person admitted to ICU during this admission?		- Enter Yes, No or Unknown
- **IF YES**, transferred to another hospital for care?		- Enter Yes, No or Unknown
Was there a maternal death related to COVID-19 illness?		- Enter Yes, No or Unknown
- **IF YES**, date of death	dd-mm-yy	- Leave blank if not applicable

Client treatment for COVID-19 illness in pregnancy or at birth		
CORE VARIABLES		
Did person receive ventilatory support during a hospital admission for COVID-19 illness?	○ Yes – ECMO ○ Yes – Invasive Mechanical Ventilation ○ Yes – Non-invasive Mechanical Ventilation ○ No	Enter Yes and type, or No. If more than one type of support was used during the admission, indicate the most invasive option
- Date when ventilatory support was initiated	dd-mm-yy	

Newborn(s) SARS-CoV-2 testing (if a birth occurred during this clinical encounter)		
CORE VARIABLES		
Was there at least one **POSITIVE** SARS-CoV-2 test performed on the infant(s)?	<u>Baby B, if twins:</u>	- Enter Yes, No or Unknown - If twins, choose option for Baby A and Baby B
- **IF YES**, select the type of test	PCR: Other (specify): <u>Baby B, if twins:</u> PCR: Other (specify):	- If there were multiple positive tests, prioritize PCR testing. Otherwise, select the first test that was positive
- **IF YES**, sample collection date	dd-mm-yy <u>Baby B, if twins:</u> dd-mm-yy	- Leave blank if no test

ADDITIONAL COMMENTS	
	- Leave blank if no comments