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

See BORN Q & A document for additional details about data collection.

- BORN Ontario is shortening the CRF to reflect the changing pandemic priorities.
- We are collecting case information from individual hospitals and midwifery practice groups; this information will be securely transferred to BORN Ontario and linked with the BORN Information System (BIS) to obtain pregnancy outcomes.
- Do **not** send case reports form through email (use BIS messaging or BORN secure FTP server). Detailed instructions on how to securely transfer case reports to BORN can be found on questions 19 and 20 in the 'Frequently Asked Questions' document on the BORN website.

Update re Data Collection (January 2022):

BORN has received questions about submitting suspected or probable cases or cases detected with rapid antigen tests. In the absence of PCR testing availability please use your best clinical judgement on deciding whether to include suspected or probable cases.

We suggest including probable/suspected cases (even if no PCR test was completed) when there are:

1. highly suspicious clinical signs/symptoms and
   the individual has been in close contact with an infected person **or**
2. the individual tested positive on a rapid antigen test

Data should be collected for pregnant individuals at the time of birth for:

1) Any pregnant individual with **CURRENT** COVID-19 (confirmed, suspected or probable) at the time of hospital birth or out-of-hospital birth
2) Any pregnant individuals at the time of hospital birth or out-of-hospital birth with a **PAST HISTORY** of COVID-19 during this pregnancy (confirmed, suspected or probable) from which they have recovered

There are two data collection options (both within this data collection form):

OPTION A: CORE DATASET: variables required for record linkage to the BORN Information System (BIS) + core variables about COVID-19

- ***These core variables are shaded in light red***
- ***These core variables are the priority***
- ***Please complete ALL core variables (shaded)***

OPTION B: EXPANDED DATASET: core dataset variables + additional clinical variables about COVID-19

- ******This dataset is preferred, if possible***
- ***Please complete ALL core variables (shaded), as well as all other applicable variables as completely as possible***

SUBMITTING ORGANIZATION:	**DATE CASE FORM COMPLETED:** d-mmm-yy

Identifiers required for record linkage with BORN Information System (BIS)		
Mother's last/family name(s)		
Mother's first/given name(s)		
Mother's date of birth (DOB)	d-mmm-yy	
Mother's province of residence		- Use 'Other' for non-residents (e.g., a visitor to Canada)
Mother's health card number (e.g., OHIP; RAMQ; Public Service Health Care Plan)		- Use upper case for any letters - No spaces and no dashes between any letters or digits (e.g.,1111111111AA)
Mother's residence postal code		- No space between first three and last three characters (e.g., M5S1W7)
Mother's hospital chart number		- For out of hospital births add Midwifery Client Code
Estimated date of birth (EDB)	d-mmm-yy	- Leave blank if unknown - Best estimate of date of birth determined by ultrasound or mathematical calculation using Nägele's rule. Same as EDC and EDD.

Maternal SARS-CoV-2 testing (performed in pregnancy or at birth)		
CORE VARIABLES		
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	d-mmm-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	d-mmm-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	d-mmm-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

Maternal COVID-19 clinical symptoms observed or reported in pregnancy or at birth		
CORE VARIABLES		
Fever (>38)		
Cough		
Shortness of breath		
Headache		
Muscle pain/myalgia		
Anorexia (loss of appetite)		
Diarrhea		
Vomiting		
Malaise		
Anosmia (loss of smell)		
Loss of taste		
Sore throat		
Rhinitis		
Asymptomatic		
Other symptoms:		- Leave blank if not applicable

Maternal imaging (non-chest) related to COVID-19 illness		
Other imaging (non-chest), specify		
- **If YES, test result**		- Leave blank if not applicable

Maternal SARS-CoV-2 complications (in pregnancy or at birth)		
CORE VARIABLES		
Hospitalized for COVID-19 illness?		
- **IF YES**, date of hospital admission	d-mmm-yy	
- **IF YES**, date of hospital discharge	d-mmm-yy	- Date of discharge from *your* hospital
- **IF YES**, was person admitted to ICU during this admission?		
- **IF YES**, transferred to another hospital for care?		- Choose option from dropdown
Was there a maternal death related to COVID-19 illness?		
- **IF YES**, date of death	d-mmm-yy	- Leave blank if not applicable
ADDITIONAL CLINICAL VARIABLES		
Pneumonia?		
- **IF YES**, date	d-mmm-yy	- Leave blank if not applicable
Sepsis?		
- **IF YES**, date	d-mmm-yy	- Leave blank if not applicable
Respiratory failure?		
- **IF YES**, date	d-mmm-yy	- Leave blank if not applicable
Acute respiratory distress syndrome?		
- **IF YES**, date	d-mmm-yy	- Leave blank if not applicable
Heart failure?		
- **IF YES**, date	d-mmm-yy	- Leave blank if not applicable

Septic shock?		
- **IF YES**, date	d-mmm-yy	- Leave blank if not applicable
Coagulopathy?		
- **IF YES**, date	d-mmm-yy	- Leave blank if not applicable
Disseminated intravascular coagulopathy?		
- **IF YES**, date	d-mmm-yy	- Leave blank if not applicable
Renal failure?		
- **IF YES**, date	d-mmm-yy	- Leave blank if not applicable
Liver dysfunction?		
- **If YES,** date	d-mmm-yy	- Leave blank if not applicable
Other, specify?		
- **IF YES,** date		- Leave blank if not applicable

Maternal 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?		If more than one type of support was used during the admission, indicate the most invasive option
- Date when ventilatory support was initiated	d-mmm-yy	
ADDITIONAL CLINICAL VARIABLES		
Start date of ECMO (if received)	d-mmm-yy	- Leave blank if not applicable
Duration of ECMO (if received)	days	- Leave blank if not applicable
Start date of invasive mechanical ventilation (if received)	d-mmm-yy	- Leave blank if not applicable
Duration of invasive mechanical ventilation (if received)	days	- Leave blank if not applicable
Start date of non-invasive mechanical ventilation (if received)	d-mmm-yy	- Leave blank if not applicable

Duration of non-invasive mechanical ventilation (if received)	days	- Leave blank if not applicable
Start date of intravenous immunoglobulin	d-mmm-yy	- Leave blank if not applicable
- **IF YES**, duration	days	- Leave blank if not applicable
Start date of high-flow nasal cannula oxygen therapy	d-mmm-yy	- Leave blank if not applicable
- **IF YES**, duration	days	- Leave blank if not applicable
Start date of any other oxygen (outside of labour and delivery)	d-mmm-yy	- Leave blank if not applicable
- **IF YES**, duration	days	- Leave blank if not applicable
Start date of renal replacement therapy	d-mmm-yy	- Leave blank if not applicable
- **IF YES**, duration	days	- Leave blank if not applicable
Other, specify		- Leave blank if not applicable
- **IF YES,** date started	d-mmm-yy	- Leave blank if not applicable
- **IF YES,** duration	days	- Leave blank if not applicable

Maternal COVID-19 medications in pregnancy or at birth		
Over-the-counter medications: acetaminophen (Tylenol)		
Over-the-counter medications: acetylsalicylic acid (Aspirin)		
Over-the-counter medications: ibuprofen (Advil, Motrin, others)		
Over-the-counter medications: Naproxen (Aleve, Naprosyn, others)		
Over-the-counter medications: Other		
- **IF YES**, specify all		- Specify all additional over-the-counter medications; separated by semi-colon - Leave blank if not applicable

Prescription medications: Corticosteroids		
- **IF YES**, specify all	Dexamethasone ☐ Other (specify) ☐	- Specify all corticosteroids; separated by semi-colon - Leave blank if not applicable
Prescription medications: Vasopressors		-
- **IF YES,** specify all		- Specify all vasopressors; separated by semi-colon - Leave blank if not applicable
Prescription medications: Steroids for fetal lung maturation		
- **IF YES**, specify all		- Specify all steroids for fetal lung maturation; separated by semi-colon - Leave blank if not applicable
Prescription medications: Chloroquine		
- **IF YES**, describe circumstance		- Describe circumstances for chloroquine prescription - Leave blank if not applicable
Prescription medications: Hydrochloroquine		
- **IF YES**, describe circumstance		- Describe circumstances for hydrochloroquine prescription - Leave blank if not applicable

Prescription medications: Colchicine		
Prescription medications: Kaletra (Lopinavir/Ritonavir)		
Prescription medications: Remdesivir		
Prescription medications: Antibiotics		
- **IF YES**, specify all		- Specify all antibiotics; separated by semi-colon - Leave blank if not applicable
- **Monoclonal Antibodies (check all that apply)**	Tocilizumab ☐ Sotrovimab ☐ Other (specify): ☐	
Prescription medications: Other		
- **IF YES**, specify all		- Specify all additional prescription medications; separated by semi-colon - Leave blank if not applicable

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)?	Baby B, if twins:	- Choose option from dropdown - If twins, choose option for Baby A and Baby B
- **IF YES**, select the type of test	PCR ☐ Other (specify) ☐ Baby B, if twins: 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	d-mmm-yy Baby B, if twins: d-mmm-yy	- Leave blank if no test

ADDITIONAL COMMENTS	
	- Leave blank if no comments