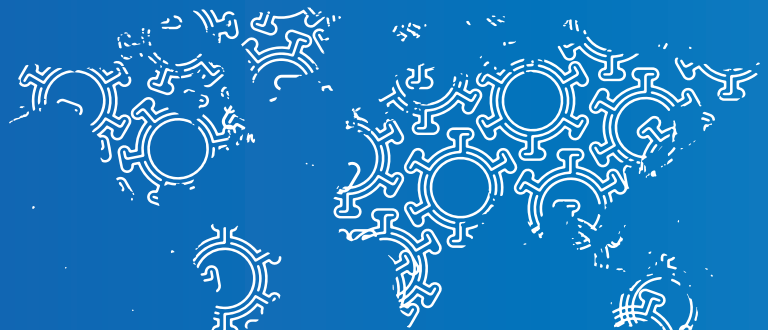


CASE REPORT FORM

for the Ean NEuro-covid ReGistrY

CRF version 3.0

powered by studienserver

eancore.com

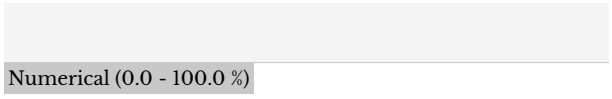
HOW TO READ

○ Radio button

This is a radio button. Only single selection is possible within one group. A radio button group has one column in exports.

☐ Checkbox

This is a checkbox. Multiple selections within one group are possible. Each checkbox has it's own column in exports.



This is a textbox. The darker box tells you which type of data is expected. Depending on the type additional information can be min and max values, decimal precision, units and expected formats for dates, times and decimals.

FOLLOW-UP

Visit date

Date (MM/dd/yyyy)

COVID Status

COVID-19 re-infection since previous visit

- ○ Yes
- ○ No

If Yes:
Variant of COVID-19 re-infection

- ○ Alpha (B.1.1.7)
- ○ Beta (B.1.351)
- ○ Gamma (P.1)
- ○ Delta (B.1.617.2)
- ○ Omicron (B.1.1.529)
- ○ My (B.1.621)
- ○ Eta (B.1.525)
- ○ Theta (P.3)
- ○ Kappa (B.1.617.1)
- ○ Lambda (C.37)
- ○ Iota (B.1.526)
- ○ Zeta (P.2)
- ○ Unknown
- ○ Other:

Text

If Yes:
Date of COVID-19 re-infection

Date (MM/dd/yyyy)

Was the patient vaccinated since previous visit?

- ○ Yes
- ○ No

If Yes:
Number of vaccination doses

Numerical (1 - *)

If Yes:
Vaccine of last dose

- ○ Spikevax (Moderna)
- ○ Comirnaty (Pfizer/BioNTech)
- ○ Janssen (Johnson & Johnson)
- ○ Vaxzevria (Oxford/AstraZeneca)
- ○ Covishield (Serum Institute of India)
- ○ Covilo (Sinopharm)
- ○ CoronaVac (Sinovac)
- ○ Unknown
- ○ Other:

Text

If Yes:
Date of last dose

Date (MM/dd/yyyy)

Modified Rankin Scale score (mRS)

Numerical (0 - 6)

If mRS = 6:
Date of death

Date (MM/dd/yyyy)

If mRS = 6:
Autopsy performed

- ○ Yes
- ○ No
- ○ Unknown

Persisting Symptoms

If mRS < 6:
Persisting symptoms after COVID

- ○ Yes
- ○ No

If persisting symptoms:
Fatigue

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Hypersomnia/EDS

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Insomnia

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Other sleep disorders

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Headache

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Muscle pain

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Altered smell

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Altered taste

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Breathing problems

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Chest pain

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Palpitations

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Impaired concentration

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Impaired memory

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Hearing impairment

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Visual impairment

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Pain/Numbness

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Depression

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Anxiety

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Altered physical fitness

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Altered quality of life

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

If persisting symptoms:
Other:

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Specify

Text

If resolved:
Month

Numerical (1 - 12)

If resolved:
Year

Numerical (2020 - *)

New Symptoms

If mRS < 6:
New symptoms after COVID

- ○ Yes
- ○ No

If new symptoms:
Did these symptoms occur after vaccination?

- ○ Yes
- ○ No

If new symptoms:
Did the patient see a doctor (non-neurologist)?

- ○ Yes
- ○ No

If new symptoms:
Did the patient see a neurologist?

- ○ Yes
- ○ No

If new symptoms:
Demyelinating or other inflammatory white matter lesions

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Onset month

Numerical (1 - 12)

If Yes:
Onset year

Numerical (2020 - *)

If new symptoms:
Dementia/other cognitive disorders

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Onset month

Numerical (1 - 12)

If Yes:
Onset year

Numerical (2020 - *)

If new symptoms:
Dysautonomia

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Onset month

Numerical (1 - 12)

If Yes:
Onset year

Numerical (2020 - *)

If new symptoms:
Hemorrhagic Stroke

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Onset month

Numerical (1 - 12)

If Yes:
Onset year

Numerical (2020 - *)

If new symptoms:
Hypoxic ischemic brain injury

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Onset month

Numerical (1 - 12)

If Yes:
Onset year

Numerical (2020 - *)

If new symptoms:
Ischemic Stroke

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Onset month

Numerical (1 - 12)

If Yes:
Onset year

Numerical (2020 - *)

If new symptoms:
Meningitis

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Onset month

Numerical (1 - 12)

If Yes:
Onset year

Numerical (2020 - *)

If new symptoms:
Parkinson's disease/Parkinsonism

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Onset month

Numerical (1 - 12)

If Yes:
Onset year

Numerical (2020 - *)

If new symptoms:
Motor Neuron Disease

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Onset month

Numerical (1 - 12)

If Yes:
Onset year

Numerical (2020 - *)

If new symptoms:
Myelopathy/Spinal Cord Disease

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Onset month

Numerical (1 - 12)

If Yes:
Onset year

Numerical (2020 - *)

If new symptoms:
Myopathy

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Onset month

Numerical (1 - 12)

If Yes:
Onset year

Numerical (2020 - *)

If new symptoms:
Neuromuscular junction disorder

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Onset month

Numerical (1 - 12)

If Yes:
Onset year

Numerical (2020 - *)

If new symptoms:
Non-traumatic subarachnoid haemorrhage

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Onset month

Numerical (1 - 12)

If Yes:
Onset year

Numerical (2020 - *)

If new symptoms:
Polyneuropathy

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Onset month

Numerical (1 - 12)

If Yes:
Onset year

Numerical (2020 - *)

If new symptoms:
Polyradiculoneuropathy (GBS)

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Onset month

Numerical (1 - 12)

If Yes:
Onset year

Numerical (2020 - *)

If new symptoms:
Radiculopathy/Plexopathy

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Onset month

Numerical (1 - 12)

If Yes:
Onset year

Numerical (2020 - *)

If new symptoms:
Seizures/Epilepsy

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Onset month

Numerical (1 - 12)

If Yes:
Onset year

Numerical (2020 - *)

If new symptoms:
Toxic/Metabolic Encephalopathy

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Onset month

Numerical (1 - 12)

If Yes:
Onset year

Numerical (2020 - *)

If new symptoms:
Other neurological:

- ○ No
- ○ Yes, persisting
- ○ Yes, resolved

If Yes:
Specify

Text

If Yes:
Onset month

Numerical (1 - 12)

If Yes:
Onset year

Numerical (2020 - *)

Other Diseases

If mRS < 6:
Does the patient have any pre-existing diseases?

- ○ Yes
- ○ No

If Yes:
Does the patient attend periodical control visits for pre-existent diseases?

- ○ Yes
- ○ No

If No:
Please select the most suitable choice

- ○ Because of fear of in-hospital infection
- ○ Inefficient leading by family practitioners or otherdoctors in primary level
- ○ Disrupted functioning at contact center
- ○ Because of milder symptoms
- ○ Lack of family members or bystanders to activateemergency services
- ○ Lack of contact with others
- ○ Because of warning about stay-at- home andsocial distancing practices

Insomnia Severity Index

If mRS < 6:
Has the survey been conducted?

- ○ Yes
- ○ No

If Yes:
Difficulty falling asleep

- ○ None
- ○ Mild
- ○ Moderate
- ○ Severe
- ○ Very severe

If Yes:
Difficulty staying asleep

- ○ None
- ○ Mild
- ○ Moderate
- ○ Severe
- ○ Very severe

If Yes:
Problem waking up too early in the morning

- ○ None
- ○ Mild
- ○ Moderate
- ○ Severe
- ○ Very severe

If Yes:
How SATISFIED/dissatisfied are you with your current sleep pattern?

- ○ Very satisfied
- ○ Satisfied
- ○ Neutral
- ○ Dissatisfied
- ○ Very dissatisfied

If Yes:
To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, ability to function at work/daily chores, concentration, memory, mood)?

- ○ Not at all interfering
- ○ A little interfering
- ○ Somewhat interfering
- ○ Very interfering
- ○ Extremely interfering

If Yes:
How NOTICEABLE to others do you think your sleeping problem is in terms of impairing the quality of your life?

- ○ Not at all noticeable
- ○ A little noticeable
- ○ Somewhat noticeable
- ○ Very noticeable
- ○ Extremely noticeable

If Yes:
How WORRIED/distressed are you about your current sleep problem?

- ○ Not at all worried
- ○ A little worried
- ○ Somewhat worried
- ○ Very worried
- ○ Extremely worried

If Yes:
ISI score

Numerical (0 - 28)

If No:
What is the reason?

Text

Epworth Sleepiness Scale

If mRS < 6:
Has the survey been conducted?

- ○ Yes
- ○ No

If Yes:
Sitting and reading

- ○ Would never doze
- ○ Slight chance of dozing
- ○ Moderate chance of dozing
- ○ High chance of dozing

If Yes:
Watching TV

- ○ Would never doze
- ○ Slight chance of dozing
- ○ Moderate chance of dozing
- ○ High chance of dozing

If Yes:
Sitting still in a public place (e.g., a theatre, a cinema or a meeting)

- ○ Would never doze
- ○ Slight chance of dozing
- ○ Moderate chance of dozing
- ○ High chance of dozing

If Yes:
As a passenger in a car for an hour without a break

- ○ Would never doze
- ○ Slight chance of dozing
- ○ Moderate chance of dozing
- ○ High chance of dozing

If Yes:
Lying down to rest in the afternoon when circumstances allow

- ○ Would never doze
- ○ Slight chance of dozing
- ○ Moderate chance of dozing
- ○ High chance of dozing

If Yes:
Sitting and talking to someone

- ○ Would never doze
- ○ Slight chance of dozing
- ○ Moderate chance of dozing
- ○ High chance of dozing

If Yes:
Sitting quietly after a lunch without having drunk alcohol

- ○ Would never doze
- ○ Slight chance of dozing
- ○ Moderate chance of dozing
- ○ High chance of dozing

If Yes:
In a car, while stopped for a few minutes in traffic

- ○ Would never doze
- ○ Slight chance of dozing
- ○ Moderate chance of dozing
- ○ High chance of dozing

If Yes:
ESS score

Numerical (0 - 24)

If No:
What is the reason?

Text

Fatigue Severity Scale

If mRS < 6:
Has the survey been conducted?

- ○ Yes
- ○ No

If Yes:
My motivation is lower when I am fatigued.

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7

If Yes:
Exercise brings on my fatigue.

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7

If Yes:
I am easily fatigued.

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7

If Yes:
Fatigue interferes with my physical functioning.

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7

If Yes:
Fatigue causes frequent problems for me.

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7

If Yes:
My fatigue prevents sustained physical functioning.

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7

If Yes:
Fatigue interferes with carrying out certain duties and responsibilities.

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7

If Yes:
Fatigue is among my three most disabling symptoms.

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7

If Yes:
Fatigue interferes with my work, family, or social life.

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7

If Yes:
FSS score (sum of agreement scores)

Numerical (9 - 63)

If No:
What is the reason?

Text

Quality of Life After Brain Injury

If mRS < 6:
Has the survey been conducted?

- ○ Yes
- ○ No

If Yes:
Overall, how satisfied are you with your physical condition?

- ○ Not at all
- ○ Slightly
- ○ Moderately
- ○ Quite
- ○ Very

If Yes:
Overall, how satisfied are you with how your brain is working, in terms of your concentration, memory, thinking?

- ○ Not at all
- ○ Slightly
- ○ Moderately
- ○ Quite
- ○ Very

If Yes:
Overall, how satisfied are you with your feelings and emotions?

- ○ Not at all
- ○ Slightly
- ○ Moderately
- ○ Quite
- ○ Very

If Yes:
Overall, how satisfied are you with your ability to carry out day to day activities?

- ○ Not at all
- ○ Slightly
- ○ Moderately
- ○ Quite
- ○ Very

If Yes:
Overall, how satisfied are you with your personal and social life?

- ○ Not at all
- ○ Slightly
- ○ Moderately
- ○ Quite
- ○ Very

If Yes:
Overall, how satisfied are you with your current situation and future prospects?

- ○ Not at all
- ○ Slightly
- ○ Moderately
- ○ Quite
- ○ Very

If Yes:
QoL After Brain Injury score

Numerical (0 - 100)

If No:
What is the reason?

Text

Montreal Cognitive Assessment BLIND

If mRS < 6:
Has the survey been conducted?

- ○ Yes
- ○ No

If Yes:
ATTENTION: Read list of digits

Numerical (0 - 2)

If Yes:
ATTENTION: Read list of letters

Numerical (0 - 1)

If Yes:
ATTENTION: Seria 7 subtraction starting at 60

Numerical (0 - 3)

If Yes:
LANGUAGE: Repeat

Numerical (0 - 2)

If Yes:
LANGUAGE: Fluency

Numerical (0 - 1)

If Yes:
ABSTRACTION

Numerical (0 - 2)

If Yes:
DELAYED RECALL

Numerical (0 - 5)

If Yes:
ORIENTATION

Numerical (0 - 6)

If Yes:
Total

Numerical (0 - 23)

If No:
What is the reason?

Text

Further Details

If mRS < 6:
Telephone Interview for Cognitive Status (TICS)

Numerical (0 - 41)

☐ Unknown/not possible

Finally

Any comment

Text