EAN COVID 19 MANIFESTATIONS STUDY

Identification

Name of hospital or outpatient facility

____
(Centre ID)

Institutions record number

____
(Medical Record #)

Where is the patient seen by neurologist

◯ Hospital
◯ Emergency Room
◯ Outpatient service
◯ Other, specify
(Site of visit)

Consultation vs. other

____
(Reason for neurological assessment)

Date in which the patient was first seen or discharged

____
(Date of registration)

Demographics & History

Only the year of birth to prevent identification

____
(Year of birth)

Biological sex is required

◯ Male
◯ Female
◯ Intersex
◯ Unknown
(Sex)

Enter height in centimetres
(1 - 250)

____
(Height)

Enter weight in kilograms
(1 - 400)

____
(Weight)

Current smoker

◯ Yes ◯ No ◯ Unknown
(Smoking)

Where was the most probable exposure (Occupation; Family member; Social; Travel; Other; Unknown)	◯ Occupation ◯ Family member ◯ Social ◯ Travel ◯ Other ◯ Unkown (Source of COVID-19 contact)
If exposure is other, please specify	__________________________________
Date when the patient started to notice first symptoms. Can be approximated if unknown (If Day is unkown enter 01.)	__________________________________ (Date of COVID-19 symptom onset)
Final COVID 19 test status. IF patient first tested negative and then turn positive, please code as positive.	☐ suspected ☐ confirmed ☐ PCR negative ☐ PCR positive (serum or CSF) ☐ Antibodies positive ☐ Other (FINAL COVID-19 status)

Comorbidities in history

Any comorbidity with impact on patients perceived health? If yes, specify in the next questions	◯ Yes ◯ No (Comorbidities)
History of hypertension or taking anti-hypertensive medications prior to admission	◯ Yes ◯ No ◯ Unknown (Arterial hypertension)
History of diabetes (types 1 or 2) or taking antidiabetic medications	◯ Type 1 ◯ Type 2 ◯ Unkown ◯ No ◯ Other specify (Diabetes)
If diabetes is other, please define	__________________________________
History of cardiovascular disease (myocardial infarction; chronic heart failure, coronary artery disease, peripheral artery disease or taking cardiovascular drugs)	◯ Yes ◯ No ◯ Unknown (Cardiovascular Disease)
History of any disease affecting liver function	◯ Yes ◯ No ◯ Unknown (Chronic liver disease)
History of any disease affecting renal function (includes undergoing dialysis)	◯ Yes ◯ No ◯ Unknown (Chronic kidney disease)
History of any disease affecting lung function (includes chronic obstructive pulmonary disease, asthma)	◯ Yes ◯ No ◯ Unknown (Chronic pulmonary disease)

History of decrease in whole-blood Hb concentration requiring treatment	◯ Yes ◯ No ◯ Unknown (Anemia)
Any neoplasm with impact on patients health	◯ Yes ◯ No ◯ Unknown (Cancer)
Pre-existing immunosuppressed state (taking immunosuppresants/chemotherapy, chronic steroids, hematologic malignancy, HIV, other immunodeficiency syndrome)	◯ Yes ◯ No ◯ Unknown (Immunosuppressed state)
Any other non-neurological disease with impact on patients health	◯ Yes ◯ No ◯ Unknown (Other non-neurological)
If alive, calculate mRS score (0 - 6)	__________________ (Modified Rankin Scale (mRS))
Any neurological disease with impact on patients health (Dementia; Parkinson; disease, Stroke: ICH, schemic stroke, Tia; Multiple sclerosis; Motor neuro disease; Neuromuscular disorder; Other)	☐ Dementia ☐ Parkinson disease ☐ Stroke: ICH, schemic stroke, TIA ☐ Multiple sclerosis ☐ Motor neuro disease ☐ Neuromuscular disorder ☐ Other ☐ Unkown (Neurological)
If other, please specify	__________________

COVID-19 Related Systemic Complications

Was the patient admitted to the hospital?	◯ Yes ◯ No ◯ Unknown (Hospital admission)
Was the patient admitted to the ICU?	◯ Yes ◯ No ◯ Unknown (Intensive Care Unit admission)
Did the patient receive mechanical ventilation?	◯ Yes ◯ No ◯ Unknown (Mechanical ventilation)
Shortness of breath not explained by an overt pulmonary disease (e.g. pneumonia, ARDS)	◯ Yes ◯ No ◯ Unknown (Dyspnea)
Did the patient develop clinical or radiographic evidence of pneumonia?	◯ Yes ◯ No ◯ Unknown (Pneumonia)
Did the patient develop cardiac complications? (including myocardial infarction)	◯ Yes ◯ No ◯ Unknown (Cardiovascular disease)
Did the patient develop acute kidney injury requiring dialysis/continuous renal replacement therapy (CRRT)	◯ Yes ◯ No ◯ Unknown (Renal insufficiency/dialysis)

Did the patient develop any coagulation disorder /Disseminated intravascular coagulation?	◯ Yes ◯ No ◯ Unknown (Coagulation disorder /Disseminated intravascular coagulation)
Did the patient experience refractory shock while hospitalized?	◯ Yes ◯ No ◯ Unknown (Refractory Shock)
Did the patient require ECMO therapy while hospitalized?	◯ Yes ◯ No ◯ Unknown (Extra-Corporeal Membrane Oxygenation (ECMO))
Did the patient develop another complication? If yes, specify	________________________________ (Other)

New Neurological Findings

Did the patient have any neurological complaint?	◯ Yes ◯ No (Neurological findings)
New-onset headache in patient with no hx of headache	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Headache)
Did patient have abnormal smell or taste before or during hospitalization for COVID-19 (self-reported or family reported)	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Hyposmia/Hypogeusia)
Did the patient exhibit signs/symptoms of dysautonomia?	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Dysautonomia)
Did the patient report about dizziness with the feeling that (s)he or the objects around are moving when they are not?	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Vertigo)
Did patient develop/complain about myalgia?	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Myalgia)
Did patient develop excessive daytime sleepiness (involuntary napping, daily) and/or hypersomnia (>10 hours sleep/24h)?	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Sleepiness/ Hypersomnia)
Did the patient complain/exhibit a disturbance of sleep or a non-restorative sleep?	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Sleep disturbances)
Did the patient develop any symptoms of higher functions impairment (amnesia, aphasia, apraxia, agnosia, etc)	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Cognitive impairment)
Does the patient present inattention, disorientation, poorly organized movements in response to command in off-sedation?	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Dysexecutive syndrome)

Did the patient develop delirium (acute mental disturbance characterized by confused thinking and disrupted attention often accompanied by impaired speech or hallucinations)?	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Hyperactive delirium)
Did patient develop new onset altered mental status before or during hospitalization for COVID 19, EXCLUDING direct medication effect or hypotension (MAP < 60 mmHg)	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Hypoactive delirium/Acute encephalopathy)
Did patient develop stupor or coma (no speech, absent purposeful movements/reaction to painful stimuli, no eye opening or only for a short time even after painful stimuli)	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Stupor/Coma)
Did the patient exhibit transient loss of consciousness due to an insufficient blood flow to the brain?	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Syncope)
Did the patient present with transient or prolonged disruption of the brain's electrical activity accompanied by altered consciousness and/or other neurological and behavioural manifestations?	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Seizures/Status epilepticus)
Did patient have meningitis or encephalitis? (confirmed by CSF findings)	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Meningitis/Encephalitis)
Is the patient exhibiting signs of acute stroke? (confirmed by neuroimaging)	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Stroke)

Does the patient present any of new observed movement disorders (tremor, chorea, dystonia, myoclonus, dyskinesia, parkinsonism)?

	Yes	No	Assoc with COVID	Unknown
Tremor	◯	◯	◯	◯
Chorea	◯	◯	◯	◯
Dystonia	◯	◯	◯	◯
Myoclonus	◯	◯	◯	◯
Dyskinesia	◯	◯	◯	◯
Parkinsonism	◯	◯	◯	◯

Did patient have ataxia (lack of voluntary coordination of muscle movements that can include gait abnormality, speech changes, and abnormalities in eye movements)?	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Ataxia)
Did patient show signs of myelopathy or evidence of myelitis (confirmed by CSF)?	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Spinal cord disorder)

Any type of impairment of peripheral nervous system	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Peripheral neuropathy)
Did the patient develop other new neurological symptoms or signs?	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (Other)

Additional Diagnosis Tools

Did the patient undergo a lumbar puncture?	◯ Yes ◯ No (CSF)
Did the patient undergo neuroimaging (CT/MRI)?	◯ Yes ◯ No ◯ Assoc with COVID ◯ Unknown (CT/MRI)

Outcome

Status at discharge	
Did the patient die?	◯ Yes ◯ No
Date of death	____________________
Autopsy	◯ Yes ◯ No ◯ Unknown
If alive, calculate mRS score (0 - 6)	____________________ (Modified Rankin Scale (mRS))
6-month follow-up	
Did the patient die?	◯ Yes ◯ No
Date of death	____________________
Autopsy	◯ Yes ◯ No ◯ Unknown
If alive, calculate mRS score (0 - 6)	____________________ (Modified Rankin Scale (mRS))
If alive, occurrence of new neurological problems	◯ Yes ◯ No
If yes, specify	____________________
12-month follow-up	
Did the patient die?	◯ Yes ◯ No

Date of death	__________________________________
Autopsy	◯ Yes ◯ No ◯ Unknown
If alive, calculate mRS score (0 - 6)	__________________________________ (Modified Rankin Scale (mRS))
If alive, occurrence of new neurological problems	◯ Yes ◯ No
If yes, specify	__________________________________

Finally

Any Comment	____
Is the Form complete	◯ Incomplete ◯ Unverified ◯ Complete