

Guide to the Compilation of the Case Record Form (CRF)

Variable	Description	Data fields
Identification		
Centre ID	Name of hospital or outpatient facility	Free text
Patient's code	Anonymized patient's assigned study ID	Alphanumeric
Site of visit	Where is the patient seen by neurologist	Drop-down list
Reason for neurological assessment	Consultation vs. other	Drop-down list
Date of registration	Date in which the patient was first seen or discharged	DD/MM/YR
Demographics & History		
Medical Record #	Institution's record number	Numeric
Year of birth	Only the year of birth to prevent identification	4-digit box
Sex	Biological sex is required	Drop-down list
Height	Enter height in centimetres	3-digit box
Weight	Enter weight in kilograms	3-digit box
Smoking	Current smoker	Yes/No
Infection		
Source of COVID-19 contact	Where was the most probable exposure (Occupation; Family member; Social; Travel; Other; Unknown)	Drop-down list
Date of COVID-19 symptom onset	Date when the patient started to notice first symptoms. Can be approximated if unknown	DD/MM/YR
FINAL COVID-19 status	PCR negative; PCR positive, Antibodies positive, other	Drop-down list
Comorbidities in history		
Comorbidities	Any comorbidity with impact on patient's perceived health	Yes/No
Arterial hypertension	History of hypertension or taking anti-hypertensive medications prior to admission	Yes/No/Unknown
Diabetes	History of diabetes (types 1 or 2) or taking antidiabetic medications	Yes/No/Unknown
Cardiovascular Disease	History of cardiovascular disease (myocardial infarction; chronic heart failure, coronary artery disease, peripheral artery disease or taking cardiovascular drugs)	Yes/No/Unknown
Chronic kidney disease	History of any disease affecting renal function (includes undergoing dialysis)	Yes/No/Unknown

Chronic liver disease	History of any disease affecting liver function	Yes/No/Unknown
Chronic pulmonary disease	History of any disease affecting lung function (includes chronic obstructive pulmonary disease, asthma)	Yes/No/Unknown
Anemia	History of decrease in whole-blood Hb concentration requiring treatment	Yes/No/Unknown
Cancer	Any neoplasm with impact on patient's health	Yes/No/Unknown
Immunosuppressed state	Pre-existing immunosuppressed state (taking immunosuppressants/chemotherapy, chronic steroids, hematologic malignancy, HIV, other immunodeficiency syndrome)	Yes/No/Unknown
Other non-neurological	Any other non-neurological disease with impact on patient's health	Yes/No/Unknown
Neurological	Any neurological disease with impact on patient's health	Drop-down list
Premorbid modified Rankin Scale score (mRS)	mRS score (0-6)	1-digit box
COVID-19 Related Complications		
Complications	Any complication requiring medical intervention and/or hospitalization	Yes/No/Unknown
Dyspnea	Shortness of breath not explained by an overt pulmonary disease (e.g. pneumonia, ARDS)	Yes/No/Unknown
Pneumonia	Did the patient develop clinical or radiographic evidence of pneumonia?	Yes/No/Unknown
Cardiovascular disease	Did the patient develop cardiac complications? (including myocardial infarction)	Yes/No/Unknown
Renal insufficiency/dialysis	Did the patient develop acute kidney injury requiring dialysis/continuous renal replacement therapy (CRRT)	Yes/No/Unknown
Coagulation disorder /Disseminated intravascular coagulation	Did the patient develop any coagulation disorder /Disseminated intravascular coagulation?	Yes, No, Unknown
Refractory Shock	Did the patient experience refractory shock while hospitalized?	Yes/No/Unknown
Extra-Corporeal Membrane Oxygenation (ECMO)	Did the patient require ECMO therapy while hospitalized?	Yes/No/Unknown
Other	Did the patient develop another complication? If yes, specify	Free text
Hospital admission	Was the patient admitted to the hospital?	Yes/No
Intensive Care Unit admission	Was the patient admitted to the ICU?	Yes/No

Mechanical ventilation	Did the patient receive mechanical ventilation?	Yes/No
New Neurological Findings		
Neurological findings	Did the patient have any neurological complaint?	Yes/No
Headache	New-onset headache in patient with no hx of headache	No/Yes/Associated with COVID-19
Hyposmia/Hypogeusia	Did patient have abnormal smell or taste before or during hospitalization for COVID-19 (self-reported or family reported)	No/Yes/Associated with COVID-19
Dysautonomia	Did the patient exhibit signs/symptoms of dysautonomia?	No/Yes/Associated with COVID-19
Vertigo	Did the patient report about dizziness with the feeling that (s)he or the objects around are moving when they are not?	No/Yes/Associated with COVID-19
Myalgia	Did patient develop/complain about myalgia?	No/Yes/Associated with COVID-19
Sleep disturbances	Did the patient complain/exhibit a disturbance of sleep or a non-restorative sleep?	No/Yes/Associated with COVID-19
Sleepiness/ Hypersomnia	Did patient develop excessive daytime sleepiness (involuntary napping, daily) and/or hypersomnia (>10 hours sleep/24h)?	No/Yes/Associated with COVID-19
Cognitive impairment	Did the patient develop any symptoms of higher functions impairment (amnesia, aphasia, apraxia, agnosia, etc)	No/Yes/Associated with COVID-19
Dysexecutive syndrome	Does the patient present inattention, disorientation, poorly organized movements in response to command in off-sedation?	No/Yes/Associated with COVID-19
Hyperactive delirium	Did the patient develop delirium (acute mental disturbance characterized by confused thinking and disrupted attention often accompanied by impaired speech or hallucinations)?	No/Yes/Associated with COVID-19
Hypoactive delirium/Acute encephalopathy	Did patient develop new onset altered mental status before or during hospitalization for COVID 19, EXCLUDING direct medication effect or hypotension (MAP < 60 mmHg)	No/Yes/Associated with COVID-19
Stupor/Coma	Did patient develop stupor or coma (no speech, absent purposeful movements/reaction to painful	No/Yes/Associated with COVID-19

	stimuli, no eye opening or only for a short time even after painful stimuli)	
Syncope	Did the patient exhibit transient loss of consciousness due to an insufficient blood flow to the brain?	No/Yes/Associated with COVID-19
Seizures/Status epilepticus	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?	No/Yes/Associated with COVID-19
Meningitis/Encephalitis	Did patient have meningitis or encephalitis? (confirmed by CSF findings)	No/Yes/Associated with COVID-19
Stroke	Is the patient exhibiting signs of acute stroke? (confirmed by neuroimaging)	No/Yes/Associated with COVID-19
Movement disorder	Does the patient present any of new observed movement disorders (tremor, chorea, dystonia, myoclonus, dyskinesia, parkinsonism)?	No/Yes/Associated with COVID-19
Ataxia	Did patient have ataxia (lack of voluntary coordination of muscle movements that can include gait abnormality, speech changes, and abnormalities in eye movements)?	No/Yes/Associated with COVID-19
Spinal cord disorder	Did patient show signs of myelopathy or evidence of myelitis (confirmed by CSF)?	No/Yes/Associated with COVID-19
Peripheral neuropathy	Any type of impairment of peripheral nervous system	No/Yes/Associated with COVID-19
Other	Did the patient develop other new neurological symptoms or signs?	No/Yes/Associated with COVID-19
CSF	Did the patient undergo a lumbar puncture?	No/Yes/Findings associated with neurological disease
CT/MRI	Did the patient undergo neuroimaging (CT/MRI)?	No/Yes/Findings associated with neurological disease
Outcome		
Status at discharge		
Modified Rankin Scale score (mRS)	mRS score (0-6)	1-digit box
If mRS = 6	Date of death	MM/DD/YR
	Autopsy performed?	No/Yes
Modified Rankin Scale (mRS)	mRS score (0-6)	1-digit box
6-month follow-up		

Modified Rankin Scale score (mRS)	mRS score (0-6)	1-digit box
	If alive, are there remaining neurological problems since discharge?	No/Yes/NA
	If alive, occurrence of new neurological problems since discharge	No/Yes
	If yes, specify	Free text
	If mRS =6, date of death	MM/DD/YR
	Autopsy performed?	No/Yes
12-month follow-up		
Modified Rankin Scale score (mRS)	mRS score (0-6)	1-digit box
	If alive, are there remaining neurological problems since discharge?	No/Yes/NA
	If alive, occurrence of new neurological problems since discharge	No/Yes
	If yes, specify	Free text
	If mRS =6, date of death	MM/DD/YR
	Autopsy performed?	No/Yes