

Raptor eCRF (all cohorts)

1. Demographic Information

a. What is your gender?*

- Male Female Other

b. What is your age?* _____

c. What is your ethnicity?*

- White - English, Welsh, Scottish, Northern Irish or British
- White – Irish
- White - Gypsy or Irish Traveller
- White – any other White background
- Mixed or Multiple ethnic groups - White and Black Caribbean
- Mixed or Multiple ethnic groups - White and Black African
- Mixed or Multiple ethnic groups - White and Asian
- Mixed or Multiple ethnic groups - Any other Mixed or Multiple ethnic background
- Asian or Asian British – Indian
- Asian or Asian British – Pakistani
- Asian or Asian British – Bangladeshi
- Asian or Asian British – Chinese
- Asian or Asian British - Any other Asian background
- Black, African, Caribbean or Black British – African
- Black, African, Caribbean or Black British - Caribbean
- Black, African, Caribbean or Black British - Any other Black, African or Caribbean background

- Other ethnic group - Arab
- Other ethnic group - Any other ethnic group

d. Do you smoke tobacco?*

- Past
- Current
- Never

e. Do you use electronic cigarettes?*

- Past
- Current
- Never

2. Symptoms

a. What symptoms of COVID-19 have you experienced (at present or that have resolved up to two weeks ago?). Please select all that apply. For each symptom selected, please add the start and end dates. If you are still experiencing the symptom, only add the start date.

- Fever *Start date:_____ End date:_____*
- Cough *Start date:_____ End date:_____*
- Fatigue *Start date:_____ End date:_____*
- Shortness of breath *Start date:_____ End date:_____*
- Sputum production *Start date:_____ End date:_____*
- Loss of sense of smell *Start date:_____ End date:_____*
- Change in sense of taste *Start date:_____ End date:_____*
- Achey muscles *Start date:_____ End date:_____*
- Chills *Start date:_____ End date:_____*
- Dizziness *Start date:_____ End date:_____*
- Headache *Start date:_____ End date:_____*

- Sore throat *Start date:* _____ *End date:* _____
- Hoarseness *Start date:* _____ *End date:* _____
- Nausea *Start date:* _____ *End date:* _____
- Vomiting *Start date:* _____ *End date:* _____
- Diarrhoea *Start date:* _____ *End date:* _____
- Nasal congestion *Start date:* _____ *End date:* _____
- Other – please specify: _____

Start date: _____ *End date:* _____

3. Household COVID-19 Contacts (diagnosed)

a. Has anybody who lives with you been diagnosed with COVID-19 with a test?*

- Yes No

If yes, when was the diagnosis confirmed? (please provide an approximate date if unsure):* *Start date:* _____

4. Household COVID-19 Contacts (suspected)

a. Has anybody who lives with you had suspected COVID-19 but has not been tested?*

- Yes No

If yes, when was the diagnosis suspected? (please provide an approximate date if unsure):* *Start date:* _____

5. Care Home Resident

a. Are you a resident of a care home?*

- Yes No

6. Vaccine Status

a. Have you had a COVID-19 vaccine?*

- Yes No

If yes, which vaccine have you had? _____

7. Previous COVID-19 Swab

a. Have you had a previous positive COVID-19 swab?*

- Yes No

If yes, what was the date of the most recent positive swab? _____

8. Eligibility Criteria

a. On what basis does this participant meet the eligibility criteria?*

- Adult with suspected current COVID-19 infection following a recent clinical contact
- Adult with suspected past COVID-19 infection following a recent clinical contact
- Adult with suspected current COVID-19 infection following electronic health records review
- Adult with suspected past COVID-19 infection following electronic health records review

- Adult with suspected current COVID-19 infection following close contact with a positive COVID-19 case
- Adult with suspected past COVID-19 infection following close contact with a positive COVID-19 case
- Young person with suspected current COVID-19 infection following a recent clinical contact
- Young person with suspected current COVID-19 infection following electronic health records review
- Young person with suspected current COVID-19 infection following close contact with a positive COVID-19 case

9. Clinical Observations

a. Please record the following observation, if able to do so:

Current temperature (°C): _____

Pulse oximetry (%): _____

Heart rate (bpm): _____

10. Point of Care Test Selection

a. Which test are you filling in the data for?*

- SD Biosensor BD Veritor

11. Point of Care Test - SD Biosensor

Please follow the instructions provided about how to use each test, how to interpret the results, and how to dispose of the test. Please do not use the results of the point of care test to inform clinical care as these tests have not been evaluated to be accurate in primary care. Please rely on the laboratory test results to inform clinical care.

a. POCT batch/lot number* _____

b. Time sample taken:* _____

c. Time sample analysed:* _____

d. Please add a picture of the test: _____

e. What was the result?*

- Positive Negative Unknown/No result

If you didn't obtain a result or the result is unknown, please complete another SD Biosensor test:

i) POCT batch/lot number* _____

ii) Time sample taken:* _____

iii) Time sample analysed:* _____

iv) Please add a picture of the test: _____

v) What was the result?

- Positive Negative Unknown

f. Did you/the participant find the test easy to use? (1 – not very, 5 – very)*

- 1 2 3 4 5

g. Was there a problem with the test?*

- Yes No

i) If yes, please specify: _____

12. Point of Care Test - BD Veritor

Please follow the instructions provided about how to use each test, how to interpret the results, and how to dispose of the test. Please do not use the results of the point of care test to inform clinical care as these tests have not been evaluated to be accurate in primary care. Please rely on the laboratory test results to inform clinical care.

a. POCT batch/lot number* _____

b. Time sample taken:* _____

c. Time sample analysed:* _____

d. Please add a picture of the test: _____

e. What was the result?*

Positive Negative Unknown/No result

If you didn't obtain a result or the result is unknown, please complete another BD Veritor test:

i) POCT batch/lot number* _____

ii) Time sample taken:* _____

iii) Time sample analysed:* _____

iv) Please add a picture of the test: _____

v) What was the result?

Positive Negative Unknown

f. Did you/the participant find the test easy to use? (1 – not very, 5 – very)*

1 2 3 4 5

g. Was there a problem with the test?*

Yes No

ii) If yes, please specify: _____

13. PHE Active Infection Reference Test

a. Laboratory antigen swab completed?*

Yes No

If yes:

i) Please enter the date of the swab: _____

ii) Please enter the time of the swab: _____

iii) Did you observe the self swab?

Yes No

14. PHE Past Infection Reference Test

Skip question for anyone under 16 years of age

a. Antibody blood test completed?*

Yes No

If yes:

i) Please enter the date of the test: _____

ii) Please enter the time of the test: _____

iii) Was there a problem with venepuncture?

Yes No

If yes, please specify: _____

15. Referral Status

a. Will the participant be referred to hospital or a specialist COVID-19 clinic as a result of this appointment?*

Yes No

Please do not forget to remind the participant to book their 28 day follow-up appointment for a blood test.

Please also remind the participant that unless they are completing a paper version of the Daily Diary, they will receive an SMS from the practice the day after the appointment, with a link to complete their first Daily Diary. An SMS with a new link will be sent daily for 28 days, unless the participant responds that they feel recovered, or doesn't complete two consecutive Daily Diaries.