**International CAPO Study**

Case Report Form

**“An International, Observational Study to Evaluate Current Management of Hospitalized Patients with Community-Acquired Pneumonia”**

**July 2014**

**The data on this page are to be collected by the investigator and will not be entered into the study database. Please keep this first page of the case report form for you records in a secure place. This page is the only way to link the CAPO Case ID with the patient name for data quality queries and corrections.**

Principal Investigator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Record Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Data Collected by (Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CAPO Case ID (provided by the database): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have any questions regarding data collection or entry, please read the HAPPI Data Collection Manual that is available on the web site [www.caposite.com](http://www.caposite.com) in the Manual section located on the left of the home page. If you still have questions, please send an email to: [ctrsu@louisville.edu](mailto:ulctrsc@louisville.edu)

***\*\*\* All dates should be collected in Month/Day/Year format. All times should be collected in 24 hour time format rounded to the nearest 30 minutes (e.g. 1200 for noon, 0000 for midnight). \*\*\****

**\*\*\*\*\*\*\*\*\*\*\*CAPO PATIENT SCREENING FORM\*\*\*\*\*\*\*\*\*\*\*\*\***

**INCLUSION CRITERIA:**

**NOTES**: **Only patients diagnosed with Community Acquired Pneumonia** should be included in this study. Diagnosis of Community Acquired Pneumonia (CAP) **requires the presence of all three** of the following criteria.

|  |  |  |
| --- | --- | --- |
| 1. **New pulmonary infiltrate**. This needs to be proven on imaging (CT scan or chest x-ray). Qualifying images need to be taken within 48 hours either prior to, or following admission time. | Ο Yes | Ο No |
| 1. **Signs and Symptoms of CAP** (*At least one of the following*) 2. New or increased cough (per the patient) 3. Fever >37.8o C (100.0o F) or hypothermia <35.6o C (96.0o F). This can be either from patient report or hospital record. 4. Changes in WBC (leukocytosis by lab, left shift > 10% band forms/microliter, or leukopenia i.e. leukocyte count < 4.0 thousand /microliter([1](#_ENREF_1))) | Ο Yes | Ο No |
| 1. **Working diagnosis of CAP** at the time of hospital admission with antimicrobial therapy given within 24 hours of admission. | Ο Yes | Ο No |

**Frequently asked questions regarding inclusion to the CAPO study**

1. Can a patient with the diagnosis of Healthcare-Associated Pneumonia (HCAP) be included in the study?
   1. Yes. From the CAPO study perspective, patients with HCAP are considered patients with CAP who have risk factors for multidrug-resistant organisms.

**EXCLUSION CRITERION**

**\*\*\* If either exclusion criteria are marked “Yes” do not continue data collection and do not enter this case into the CAPO database.\*\*\***

|  |  |  |
| --- | --- | --- |
| 1. Discharge from any hospital in the 7 days prior to current episode of CAP | Ο Yes | Ο No |

**Frequently asked questions regarding exclusion criteria in the CAPO study**

1. Can a patient with a diagnosis of hospital-acquired pneumonia (HAP) be excluded in the CAPO study?
   1. YES, **exclude this patient**. From the CAPO study perspective, patients that were discharged from the hospital within 7 days are considered to have HAP and **should be excluded**.
2. The patient was admitted with a working diagnosis of CAP, but at the time of discharge an alternative diagnosis of urinary tract infection (UTI) and congestive heart failure (CHF) explained the pulmonary infiltrate, fever and leukocytosis. Should this patient be excluded from the CAPO study?
   1. YES, **exclude this patient**. The goal of the CAPO study is to enroll only patients with a diagnosis of CAP. If at the time of hospital discharge, an alternative diagnosis other than CAP was reached, the patient should be excluded. However, if the patient has CAP plus another infection, this patient should not be excluded.

**\*\*\* Principal Investigator opinion overrides any inclusion/exclusion criteria\*\*\***

**DATA COLLECTION**

|  |  |  |
| --- | --- | --- |
| CAPO Case ID (assigned by database): | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| Hospital: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Data were collected: | Ο Prospectively | Ο Retrospectively |

**DEMOGRAPHICS AND HOSPITALIZATION**

|  |  |  |
| --- | --- | --- |
| Age | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| Gender | Ο Male | Ο Female |
| If female, is she pregnant? | Ο Yes  Ο No  O Puerperal State | |
| If pregnant, what trimester? | Ο 1st  Ο 2nd  Ο 3rd | |

Date of Arrival to Hospital (Day 0): \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (mm/dd/yyyy)

\*\* For this study date of arrival to the hospital is study day 0, which ends at midnight of that day.

Time of Arrival to Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (hh:mm)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Was the patient admitted directly to an intensive care unit from the emergency department? | | | Ο Yes | Ο No |
| **If no,** was the patient transferred to an intensive care unit after admission to the hospital? | | | Ο Yes | Ο No |
| If the patient was transferred to an intensive care unit after admission to the hospital, please enter the date of transfer | | | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_  (mm/dd/yyyy) | |
| Did the patient need ventilatory support on day 0? | | | Ο Yes | Ο No |
| **If yes,** type | Ο Invasive mechanical ventilation | Ο Non-invasive mechanical ventilation (e.g. CPAP/BiPAP) | | |
| Did the patient need vasopressors on day 0? | | | Ο Yes | Ο No |

Date of discharge from the ICU: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy)

Date of discharge from the hospital: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (mm/dd/yyyy)

**PATIENT HISTORY**

**Notes**: Ensure all data are entered as requested. For all “yes/no” answers, if unknown, select “no”.

|  |  |  |  |
| --- | --- | --- | --- |
| Is the number of days with respiratory symptoms before day 0 known? | Ο Yes | Ο No | |
| If this is known, enter the number of days with respiratory symptoms before day 0. | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| *Past Social and Medical History* |  |  | |
| Neoplastic disease (active or within the last year) | Ο Yes | Ο No | |
| Congestive heart failure | Ο Yes | Ο No | |
| Cerebrovascular disease | Ο Yes | Ο No | |
| Renal disease | Ο Yes | Ο No | |
| Liver disease | Ο Yes | Ο No | |
| Chronic renal failure | Ο Yes | Ο No | |
| Diabetes | Ο Yes | Ο No | |
| If yes, insulin dependent? | Ο Yes | Ο No | |
| If yes, do you have most recent HgA1c prior to hospitalization? | Ο Yes | Ο No | |
| Most recent HgA1c prior to hospitalization | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Suspicion of aspiration | Ο Yes | Ο No | |
| Cirrhosis | Ο Yes | Ο No | |
| Asplenia | Ο Yes | Ο No | |
| Alcoholic | Ο Yes | Ο No | |
| IV steroids on day 0: | Ο Yes | Ο No | |
| If yes, name | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| COPD | Ο Yes | Ο No | |
| If yes, on oral steroids prior to day 0 | Ο Yes | Ο No | |
| If yes, do you have most recent FEV1 (%) within the past year | Ο Yes | Ο No | |
| If yes, most recent FEV1 (%) within the past year | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| If yes, is home oxygen therapy required? | Ο Yes | Ο No | |
| Active intravenous drug use? | Ο Yes | Ο No | |
| HIV | Ο Yes | Ο No | |
| If yes, please answer the following: |  | | |
| Do you have most recent CD4 in the past year (absolute)? | Ο Yes | Ο No | |
| Most recent CD4 in the past year (absolute) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Do you have most recent CD4 in the past year (percent) | Ο Yes | | Ο No |
| Most recent CD4 in the past year (percent) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Do you have most recent viral loadin the past year? | Ο Yes | | Ο No |
| Most recent viral loadin the past year | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Do you have duration of HIV seropositivity (years) | Ο Yes | | Ο No |
| Duration of HIV seropositivity (years) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Currently on anti-retroviral therapy? | Ο Yes | Ο No | |
| Current episode of CAP as initial presentation of HIV | Ο Yes | Ο No | |
| Prior AIDS defining illness | Ο Yes | Ο No | |
| Prior history of PCP | Ο Yes | Ο No | |
| Prior history of tuberculosis | Ο Yes | Ο No | |
| Antibiotic prophylaxis for PCP | Ο Yes | Ο No | |
| Antibiotic prophylaxis for MAC | Ο Yes | Ο No | |
|  |  |  | |
| *Risk factors for healthcare-associated pneumonia (HCAP)* |  |  | |
| Nursing home resident | Ο Yes | Ο No | |
| Hospitalized ≥ 2 days in the prior 90 days | Ο Yes | Ο No | |
| IV antibiotic therapy in the prior 90 days | Ο Yes | Ο No | |
| Home infusion therapy (including ABT and chemotherapy) | Ο Yes | Ο No | |
| Chronic dialysis within prior 30days | Ο Yes | Ο No | |
| Home wound care | Ο Yes | Ο No | |
|  |  |  | |
| *Risk factors for cardiovascular events* |  |  | |
| Family history of coronary artery disease | Ο Yes | Ο No | |
| Coronary artery disease | Ο Yes | Ο No | |
| Essential arterial hypertension | Ο Yes | Ο No | |
| Hyperlipidemia | Ο Yes | Ο No | |
| Prior myocardial infarction | Ο Yes | Ο No | |
| Prior PTCA/CABG | Ο Yes | Ο No | |
| Atrial fibrillation | Ο Yes | Ο No | |
|  |  |  | |
| *Cardiovascular medications prior to hospital admission* |  |  | |
| Aspirin | Ο Yes | Ο No | |
| Beta-blockers | Ο Yes | Ο No | |
| ACE inhibitors | Ο Yes | Ο No | |
| Warfarin | Ο Yes | Ο No | |
| Heparin | Ο Yes | Ο No | |
| Antiplatelet | Ο Yes | Ο No | |
| Statins | Ο Yes | Ο No | |

**PHYSICAL EXAMINATION AND LABORATORY AT ADMISSION**

\*The period of admission includes the first 24 hours since the time that the patient arrived to the hospital. Vital signs and laboratory values should be collected during the first 24 hours only. If more than one value per field exists, select the **worst value** for the first 24 hours. If no value is available, mark “Not Done”.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Physical examination on admission* |  | | |  |
| Height (centimeters) | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | Ο Not done |
| Weight (kilograms) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Heart rate (Beats/Minute) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Respiratory rate (Breaths/Minute) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Systolic blood pressure (mmHg) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Diastolic blood pressure (mmHg) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Temperature (Degrees Celsius) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| O2 saturation collected? | Ο Yes | Ο No | |  |
| If yes, O2 saturation (%) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |
| FiO2 at the time of O2 saturation measurement (%) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| *Laboratory findings* |  | | |  |
| Hematocrit % | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Hemoglobin (mg/dL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| White Blood Cell Count (x 103/µL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Bands (%) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Platelet count (x 103/µL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| INR [International Normalized Ratio] |  | | | Ο Not done |
| Serum sodium (mEq/L) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Serum potassium (mEq/L) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Blood Urea Nitrogen (BUN) (mg/dL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Serum creatinine (mg/dL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Serum bicarbonate (mEq/L) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Serum glucose (mg/dl) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Albumin (g/dL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Aspartate transaminase (AST) (units/L) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Alanine transferase (ALT) (units/L) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Bilirubin (mg/dL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Serum troponin I (ng/mL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Serum troponin II (ng/mL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Serum troponin III (ng/mL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Serum CK-MB 1 (ng/mL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Serum CK-MB 2 (ng/mL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Serum CK-MB 3 (ng/mL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Low Density Lipoprotein (LDL) (mg/dL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| High Density Lipoprotein (HDL) (mg/dL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Cholesterol (mg/dL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Triglycerides (mg/dL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Lactate (mg/dL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Lactate Dehydrogenase (LDH) (units/L) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Brain natriuretic peptide (BNP) (pg/mL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| C-reactive protein (CRP) (mg/L) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Procalcitonin (µg/L) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| 25-hydroxy Vitamin D (pg/mL) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ο Not done |
| Was arterial blood gas (ABG) obtained? | Ο Yes | | Ο No |  |
| If yes, pH (pH units) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |
| If yes, PaCO2 (mm Hg) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |
| If yes, PaO2 (mm Hg) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |
| If yes, bicarbonate (mEq/L) | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |  |
| If yes, FiO2 (%) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |

**RADIOLOGICAL FINDINGS**

**Notes:** A pulmonary infiltrate can be diagnosed with a chest X-ray or a CT scan obtained within 48 hours before or 48 hours after time of arrival. CT scan findings, if present, override chest X-ray findings. Example: If an infiltrate is seen on CT but not chest x-ray, HAPPI inclusion criteria are met. If an infiltrate not seen on CT but reported on chest x-ray the new pulmonary infiltrate criterion is NOT met.

***1. Chest X-ray within 48 hours of admission***

|  |  |  |
| --- | --- | --- |
| Was Chest X-ray done? | Ο Yes | Ο No |

Date of x-ray \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) Time of x-ray \_\_\_\_\_\_\_\_\_\_\_\_\_ (hh:mm)

*New pulmonary infiltrate*

|  |  |  |
| --- | --- | --- |
| Right Upper Lobe | Ο Yes | Ο No |
| Right Middle Lobe | Ο Yes | Ο No |
| Right Lower Lobe | Ο Yes | Ο No |
| Left Upper Lobe | Ο Yes | Ο No |
| Left Lower Lobe | Ο Yes | Ο No |
| Diffuse Bilateral | Ο Yes | Ο No |
| Diffuse unilateral | Ο Yes | Ο No |

*Cavitation*

|  |  |  |
| --- | --- | --- |
| Cavitation | Ο Yes | Ο No |

*Pleural Effusion*

|  |  |  |  |
| --- | --- | --- | --- |
| Ο None | Ο Right | Ο Left | Ο Bilateral |

***2. CT Scan within 48 hours of admission***

|  |  |  |
| --- | --- | --- |
| Was CT done? | Ο Yes | Ο No |

Date of CT scan done: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) Time of CT scan \_\_\_\_\_\_\_\_\_\_\_ (hh:mm)

*New pulmonary infiltrate*

|  |  |  |
| --- | --- | --- |
| Right Upper Lobe | Ο Yes | Ο No |
| Right Middle Lobe | Ο Yes | Ο No |
| Right Lower Lobe | Ο Yes | Ο No |
| Left Upper Lobe | Ο Yes | Ο No |
| Left Lower Lobe | Ο Yes | Ο No |
| Diffuse Bilateral | Ο Yes | Ο No |
| Diffuse unilateral | Ο Yes | Ο No |

*Cavitation*

|  |  |  |
| --- | --- | --- |
| Cavitation | Ο Yes | Ο No |

*Pleural Effusion*

|  |  |  |  |
| --- | --- | --- | --- |
| Ο None | Ο Right | Ο Left | Ο Bilateral |

**RISK FACTORS FOR TUBERCULOSIS**

Answer Yes or No for each item as documented by the patient directly or in patient’s medical record. If unknown, select, “No”.

|  |  |  |
| --- | --- | --- |
| *Symptoms* |  |  |
| Night sweats | Ο Yes | Ο No |
| Hemoptysis | Ο Yes | Ο No |
| Weight loss | Ο Yes | Ο No |
| Hoarseness | Ο Yes | Ο No |
|  |  |  |
| *Member of High Risk Group* |  |  |
| HIV Positive | Ο Yes | Ο No |
| History of positive PPD, TB Gold, or T-Spot tests | Ο Yes | Ο No |
| Homeless | Ο Yes | Ο No |
| Alcohol/drug abuse | Ο Yes | Ο No |
| Healthcare worker | Ο Yes | Ο No |
| History of tuberculosis | Ο Yes | Ο No |
| Age ≥65 years | Ο Yes | Ο No |
| Community living (prison, nursing home, shelter) | Ο Yes | Ο No |
| Recent exposure to active tuberculosis | Ο Yes | Ο No |
| From area with high risk of tuberculosis | Ο Yes | Ο No |
|  |  |  |
| *History of Chronic Illness* |  |  |
| Silicosis | Ο Yes | Ο No |
| End-stage renal disease | Ο Yes | Ο No |
| Gastrectomy | Ο Yes | Ο No |
| Cancer of mouth or gastrointestinal tract | Ο Yes | Ο No |
| 10% or below ideal body weight | Ο Yes | Ο No |
| Diabetes mellitus | Ο Yes | Ο No |
| Hematologic disease | Ο Yes | Ο No |
| Intestinal bypass | Ο Yes | Ο No |
| Chronic malabsorption syndrome | Ο Yes | Ο No |
| Recent long-term cortisone therapy | Ο Yes | Ο No |
| Other immunosuppressive state | Ο Yes | Ο No |
| **AFB RESULTS** |  |  |
| Was patient diagnosed with pulmonary tuberculosis? | Ο Yes | Ο No |
| If yes, Acid Fast Bacilli (AFB) smear positive? | Ο Yes | Ο No |
| If yes, cultures positive | Ο Yes | Ο No |
| If yes, source of positive culture | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| If yes, DNA amplification (PCR) positive | Ο Yes | Ο No |
| If yes, multidrug-resistant *Mycobacterium tuberculosis?* | Ο Yes | Ο No |

**INITIAL MICROBIOLOGICAL WORKUP FOR CAP**

*(Obtained within 48 hours before or after arrival for the diagnosis of CAP)*

*Was the following workup performed?*

|  |  |  |  |
| --- | --- | --- | --- |
| Gram Stain (sputum) | Ο Yes | Ο No | |
| If yes, date of Gram Stain | \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | |
| If yes, was the specimen acceptable? | Ο Yes | | Ο No |
| If yes, predominant organism: | | | |
| **Gram positives** |  | |  |
| cocci unspecified | Ο Yes | | Ο No |
| cocci in pairs | Ο Yes | | Ο No |
| cocci in chains | Ο Yes | | Ο No |
| cocci in clusters | Ο Yes | | Ο No |
| bacilli/rods | Ο Yes | | Ο No |
| **Gram negatives** |  | |  |
| cocci | Ο Yes | | Ο No |
| cocco-bacilli | Ο Yes | | Ο No |
| bacilli/rods | Ο Yes | | Ο No |
| No predominant organism | Ο Yes | | Ο No |
| No organisms seen | Ο Yes | | Ο No |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Respiratory Culture | | | | | Ο Yes | Ο No | |
| If yes, date of respiratory culture | | | | \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | | |
| If yes, site | Ο Sputum | Ο T. aspirate | Ο BAL | Ο Other:\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | | | |  | | | |
| Blood Culture | | | | Ο Yes | | | Ο No |
| If yes, date of blood culture | | | | \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | | |
| Pneumococcal Urinary Antigen | | | | Ο Yes | | | Ο No |
| If yes, date of pneumococcal urinary antigen | | | | \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | | |
| Legionella Urinary Antigen | | | | Ο Yes | | | Ο No |
| If yes, date of legionella urinary antigen | | | | \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | | |
| Rapid Influenza Test | | | | Ο Yes | | | Ο No |
| If yes, date of rapid influenza test | | | | \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | | |
| Viral PCR | | | | Ο Yes | | | Ο No |
| If yes, date of viral PCR | | | | \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | | |
| Atypical Pathogens PCR | | | | Ο Yes | | | Ο No |
| If yes, date of atypical pathogens PCR | | | | \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Was the cause of pneumonia identified? | | Ο Yes | Ο No | |
| If yes, what was the first organism? | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| If yes, specimen type for organism 1: | |  | | |
| Blood (culture only) | | Ο Yes | | Ο No |
| Sputum/Tracheal Aspirate | | Ο Yes | Ο No | |
| Bronchoalveolar Lavage (BAL) | | Ο Yes | | Ο No |
| Urinary Antigen | | Ο Yes | Ο No | |
| Nasopharyngeal (NP) Swab | | Ο Yes | | Ο No |
| Oropharyngeal (OP) Swab | | Ο Yes | Ο No | |
| Serology | | Ο Yes | | Ο No |
| Other | | Ο Yes | Ο No | |
| If other, please list | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Relevant susceptibilities for organism 1 | | | |  | |
| Antibiotic 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Ο Susceptible | Ο Intermediate | | | Ο Resistant |
| Antibiotic 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Ο Susceptible | Ο Intermediate | | | Ο Resistant |
| Antibiotic 3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Ο Susceptible | Ο Intermediate | | | Ο Resistant |
| Antibiotic 4 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Ο Susceptible | Ο Intermediate | | | Ο Resistant |
| Antibiotic 5 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Ο Susceptible | Ο Intermediate | | | Ο Resistant |
| Antibiotic 6 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Ο Susceptible | Ο Intermediate | | | Ο Resistant |
| Antibiotic 7 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Ο Susceptible | Ο Intermediate | | | Ο Resistant |
| If the organism was *Streptococcus pneumoniae* what is the MIC for Penicillin? | | | \_\_\_\_ | | Ο Not done |
| If the organism was MRSA what is the MIC for Vancomycin? | | | \_\_\_\_ | | Ο Not done |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Was there a second organism? | | | | | Ο Yes | | Ο No |
| If yes, what was the second organism? | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | |
| Specimen type for organism 2: | | | | |  | | | |
| Blood | | | | | Ο Yes | | Ο No | |
| Sputum/Tracheal Aspirate | | | | | Ο Yes | | Ο No |
| Bronchoalveolar Lavage (BAL) | | | | | Ο Yes | | Ο No | |
| Urinary Antigen | | | | | Ο Yes | | Ο No |
| Nasopharyngeal (NP) Swab | | | | | Ο Yes | | Ο No | |
| Oropharyngeal (OP) Swab | | | | | Ο Yes | | Ο No |
| Serology | | | | | Ο Yes | | Ο No | |
| Other | | | | | Ο Yes | | Ο No |
| If other, please list | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Relevant susceptibilities for organism 2 | | | | |  | | | |
| Antibiotic 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Ο Susceptible | Ο Intermediate | | | Ο Resistant | | |
| Antibiotic 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Ο Susceptible | Ο Intermediate | | | Ο Resistant | | |
| Antibiotic 3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Ο Susceptible | Ο Intermediate | | | Ο Resistant | | |
| Antibiotic 4 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Ο Susceptible | Ο Intermediate | | | Ο Resistant | | |
| Antibiotic 5 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Ο Susceptible | Ο Intermediate | | | Ο Resistant | | |
| Antibiotic 6 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Ο Susceptible | Ο Intermediate | | | Ο Resistant | | |
| Antibiotic 7 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Ο Susceptible | Ο Intermediate | | | Ο Resistant | | |
| If the organism was *Streptococcus pneumoniae* what is the MIC for Penicillin? | | | | \_\_\_\_ | | Ο Not done | | |
| If the organism was MRSA what is the MIC for Vancomycin? | | | | \_\_\_\_ | | Ο Not done | |

**ANTIMICROBIAL THERAPY**

|  |  |  |  |
| --- | --- | --- | --- |
| Did the patient receive oral antimicrobial in the prior 30 days? | Ο Yes | Ο No | |
| If yes, was the antimicrobial given for the treatment of CAP? | Ο Yes | Ο No | |
| If yes, name of antimicrobial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| If yes, did the patient fail outpatient oral antimicrobial therapy for CAP? | Ο Yes | | Ο No |

**Antimicrobials received for therapy of CAP**

* Record antibiotics given for treatment of CAP **only**.
* All entries in this section must be completed.
* Put your entries in chronological order of the antibiotic start date.
* **If you do not know the Start Time for an antimicrobial, enter: 00:00**
* **If you do not know the Stop Date for an antimicrobial enter: 1/1/1900**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date/Time **initial** antimicrobial therapy was **administered** | | | \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_(hh:mm) | | |
| *Please indicate all antibiotics received for the therapy of CAP:* | | | | | |
| **Antimicrobial Name** | **Route** | **Start Date (mm/dd/yyyy)** | | **Start Time**  **(hh:mm)** | **Stop Date**  **(mm/dd/yyyy)** |
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| --- |
| *Please classify the initial antibiotic therapy based on the antibiotics received within the first 24 hours of admission (Please consider* ***antibiotics only*** *for this classification):* |
| Ο Beta-lactam monotherapy only |
| Ο Beta-lactam + macrolide combination only |
| Ο Beta-lactam + quinolone combination only |
| Ο Quinolone monotherapy only |
| Ο Any other antibiotic combination |

**CLINICAL COURSE – TIME TO CLINICAL STABILITY**

**Criteria for clinical stability**

**Please be aware that the format of the table changed. The days of hospitalization are now located in the rows and the criteria for clinical stability in the columns. Each criterion should be now filled vertically**

# *Definitions:*

* Day 0 (day of admission) begins at the time of hospital admission and ends at midnight that evening. The worst value on day 0 should be used as baseline. In the event that the patient is afebrile throughout the entire day 0 or with normal WBC count, then those criteria are fulfilled on day 0 and the box should be checked. Otherwise leave blank. By definition, cough and shortness of breath cannot be fulfilled on day 0 if the patient is afebrile and the WBC count is normal, as they are part of the inclusion criteria for the CAPO study.
* Day 1 begins at 00:01 on the day after hospital admission and ends at midnight of that day. On days 1 through 7, answer “Cough and shortness of breath normal or improving” and “WBC normal or improving” in comparison to the day before. Check the box if the patient is improving or is back to baseline (before this illness). Continue checking the boxes until all 4 boxes are checked on the same day.
* The first day that all 4 boxes are checked is the day that the patient reached clinical stability and is a candidate for switch from intravenous to oral antibiotics. **The remaining days should not be checked.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| D  D  A  Y  O  F  H  O  S  P  I  T  A  L  I  Z  A  T  I  O  N |  | *SYMPTOMS* | *TEMPERATURE* | *WBC* | *ORAL INTAKE* |
| *Cough and shortness of breath improving?* | *Afebrile for at least 8 hours? (< 37.8 C, <100 F)* | *WBC Normal or improving? (Drop > 10% from the prior day)* | *Oral intake and absorption are adequate?* |
| **Day 0** | ☐ | ☐ | ☐ | ☐ |
| **Day 1** | ☐ | ☐ | ☐ | ☐ |
| **Day 2** | ☐ | ☐ | ☐ | ☐ |
| **Day 3** | ☐ | ☐ | ☐ | ☐ |
| **Day 4** | ☐ | ☐ | ☐ | ☐ |
| **Day 5** | ☐ | ☐ | ☐ | ☐ |
| **Day 6** | ☐ | ☐ | ☐ | ☐ |
| **Day 7** | ☐ | ☐ | ☐ | ☐ |
| **Day > 7** | ☐ | ☐ | ☐ | ☐ |

**CLINICAL COURSE – CRITERIA FOR CLINICAL FAILURE**

**This section should be completed regardless of patient meeting criteria for clinical stability or not in the prior section.**

**Definitions**: During day 0 (day of hospitalization), the worst value for pulmonary function and hemodynamic status are considered to be baseline values. **Due to this, a patient cannot fail on day 0**.

For a patient to develop clinical failure, the pulmonary function and hemodynamic status are to be compared to the baseline values (worst values collected on day 0).

The following criteria should be evaluated daily from day 1 until the patient is discharged from the hospital, or up to day 14 if the patient is still hospitalized.

|  |  |  |
| --- | --- | --- |
| Criteria 1: Acute pulmonary deterioration with the need of invasive ventilation | Ο Yes | Ο No |
| If yes, date of invasive ventilation \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | |
|  |  |  |
| Criteria 2: Acute pulmonary deterioration with the need of non-invasive ventilation | Ο Yes | Ο No |
| If yes, date of non-invasive ventilation \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | |
|  |  |  |
| Criteria 3: Acute hemodynamic deterioration with the need of vasopressors | Ο Yes | Ο No |
| If yes, date of vasopressors \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | |
|  |  |  |
| Criteria 4: Death | Ο Yes | Ο No |
| If yes, date of death \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | |

**If any of the clinical failure criteria are checked “yes”, please complete the following section of the etiology of clinical failure.**

**If ALL of the clinical failure criteria are checked “no”, DO NOT complete the following section of the etiology of clinical failure.**

**Etiology of clinical failure**

|  |  |  |  |
| --- | --- | --- | --- |
| *Etiology 1: Progression of CAP* | | | |
| Progressive Pneumonia | Ο Yes | | Ο No |
| *Etiology 2: CAP complicated with:* | | | |
| Empyema | Ο Yes | | Ο No |
| Endocarditis | Ο Yes | | Ο No |
| Meningitis | Ο Yes | | Ο No |
| Other | Ο Yes | | Ο No |
| If other, please list | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| *Etiology 3: Severe Sepsis due to CAP* | | | |
| ARDS | Ο Yes | | Ο No |
| Septic Shock | Ο Yes | | Ο No |
| Liver Failure | Ο Yes | | Ο No |
| Renal Failure | Ο Yes | | Ο No |
| Coagulopathy | Ο Yes | | Ο No |
| Encephalopathy | Ο Yes | | Ο No |
| Other | Ο Yes | | Ο No |
| If other, please list | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| *Etiology 4: Medical complications or deterioration of comorbidities* | | | |
| Pulmonary Embolism | Ο Yes | | Ο No |
| Myocardial Infarction | Ο Yes | | Ο No |
| Cardiac Arrhythmia | Ο Yes | | Ο No |
| Gastrointestinal Bleeding | Ο Yes | | Ο No |
| Congestive Heart Failure | Ο Yes | | Ο No |
| Chronic Obstructive Pulmonary Disease (COPD) | Ο Yes | | Ο No |
| Diabetes | Ο Yes | | Ο No |
| Renal Disease | Ο Yes | | Ο No |
| Other | Ο Yes | | Ο No |
| If other, please list | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| *Etiology 5: Complication due to management of CAP* | | | |
| Hemo/Pneumothorax (Iatrogenic) | Ο Yes | Ο No | |
| Allergic Reaction to Antibiotics | Ο Yes | Ο No | |
| Hospital/Ventilator-Associated Pneumonia (HAP/VAP) | Ο Yes | Ο No | |
| Intravenous Line Infection (CLABSI) | Ο Yes | Ο No | |
| *Clostridium difficile* Infection | Ο Yes | Ο No | |
| Healthcare-Associated Urinary Tract Infection | Ο Yes | Ο No | |
| Other | Ο Yes | Ο No | |
| If other, please list | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| Etiology 6: Unknown: Defined as lack of information to classify the etiology. | Ο Yes | Ο No | |

**CARDIOVASCULAR EVENTS**

|  |  |  |  |
| --- | --- | --- | --- |
| *Was the patient taking anti-thrombotic prophylaxis during hospitalization?* | | Ο Yes | Ο No |
| *Was the patient taking systemic steroids during hospitalization?* | | Ο Yes | Ο No |
|  | | | |
| *Development of acute myocardial infarction?* | | Ο Yes | Ο No |
| If yes, select type: | Ο STEMI  Ο NSTEMI  Ο Q Wave  Ο No Q Wave | | |
| If yes, when did the acute myocardial infarction occur? | | | |
| Date of first episode: | \_\_\_/\_\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | |
| Date of second episode: | \_\_\_/\_\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | |
|  | |  |  |
| *Pulmonary edema due to congestive heart failure (acute cardiogenic pulmonary edema)?* | | Ο Yes | Ο No |
| If yes, when did the pulmonary edema occur? | | | |
| Date of first episode: | \_\_\_/\_\_\_\_/\_\_\_\_\_(mm/dd/yyyy) | | |
| Date of second episode: | \_\_\_/\_\_\_\_/\_\_\_\_\_(mm/dd/yyyy) | | |
|  | |  |  |
| *Development of new, serious arrhythmia?* | | Ο Yes | Ο No |
| If yes, select type: | Ο Flutter  Ο Atrial fibrillation  Ο Junctional supraventricular  Ο Ventricular tachycardia  Ο Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| If yes, when did the new, serious arrhythmia occur? | | | |
| Date of first episode: | \_\_\_/\_\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | |
| Date of second episode: | \_\_\_/\_\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | |
|  | |  |  |
| *Development of acute worsening of long-term arrhythmia?* | | Ο Yes | Ο No |
| If yes, select type: | Ο Atrial fibrillation/Flutter  Ο Switch of classes in Lown Classification  Ο Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| If yes, when did the acute worsening of long-term arrhythmia? | | | |
| Date of first episode: | \_\_\_/\_\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | |
| Date of second episode: | \_\_\_/\_\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | |
|  | |  |  |
| *Cerebrovascular accident?* | | Ο Yes | Ο No |
| If yes, when did cerebrovascular accident occur? | | | |
| Date of first episode: | \_\_\_/\_\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | |
| Date of second episode: | \_\_\_/\_\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | |
|  | |  |  |
| *Pulmonary embolism?* | | Ο Yes | Ο No |
| If yes, when did the pulmonary embolism occur? | | | |
| Date of first episode: | \_\_\_/\_\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | |
| Date of second episode: | \_\_\_/\_\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | |

**CLINICAL OUTCOMES**

**Notes:** Mortality and re-hospitalization should be evaluated on the day indicated after the diagnosis of CAP was made (clinic visit, telephone call). For example, mortality at 1 year should be evaluated at 1 year after the initial diagnosis of CAP.

|  |  |  |  |
| --- | --- | --- | --- |
| ***1. Clinical Outcomes at Discharge*** | | | |
|  | | | |
| Ο Alive | Ο Dead, all causes | \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | |
|  | | |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***2. Clinical Outcomes at 30 Days after Hospital Admission*** | | | | | | |
| Ο Alive | Ο Dead, all causes \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | O Unknown | |  |
|  | | | |  | | |
| Re-hospitalization | | Ο No re-hospitalization | | | | |
|  | | Ο Re-hospitalization due to CAP | | | | |
|  | | Ο Re-hospitalization not due to CAP | | | | |
|  | | Ο Unknown | | | | |
| If re-hospitalized, date of first re-hospitalization \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | | |  | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***3. Clinical Outcomes at 6 months after Hospital Admission*** | | | | | | |
| Ο Alive | Ο Dead, all causes \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | O Unknown | |  |
|  | | | |  | | |
| Re-hospitalization | | Ο No re-hospitalization | | | | |
|  | | Ο Re-hospitalization due to CAP | | | | |
|  | | Ο Re-hospitalization not due to CAP | | | | |
|  | | Ο Unknown | | | | |
| If re-hospitalized, date of first re-hospitalization \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | | |  | | |

If re-hospitalized, date of second re-hospitalization \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***4. Clinical Outcomes at 1 year after Hospital Admission*** | | | | | | |
| Ο Alive | Ο Dead, all causes \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | O Unknown | |  |
|  | | | |  | | |
| Re-hospitalization | | Ο No re-hospitalization | | | | |
|  | | Ο Re-hospitalization due to CAP | | | | |
|  | | Ο Re-hospitalization not due to CAP | | | | |
|  | | Ο Unknown | | | | |
| If re-hospitalized, date of first re-hospitalization \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy) | | | |  | | |

If re-hospitalized, date of second re-hospitalization \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy)

If re-hospitalized, date of third re-hospitalization \_\_\_\_/\_\_\_/\_\_\_\_\_ (mm/dd/yyyy)

**PREVENTION OF CAP**

|  |  |
| --- | --- |
| Was the patient given pneumococcal vaccination during the current hospitalization? | Ο Yes  Ο No, because the patient already received the vaccine  Ο No, because the patient refused  Ο No, because the patient died  Ο No, no reason found |
| If patient already received the vaccine, approximate year of receipt | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| If yes or patient already received the vaccine, which vaccine did they receive? | Ο Polysaccharide pneumococcal vaccine  Ο Conjugated pneumococcal vaccine  Ο Unknown |
| Was the patient given influenza vaccination during the current hospitalization? | Ο Yes  Ο No, because the patient already received the vaccine  Ο No, because the patient refused  Ο No, because the patient died  Ο No, because the vaccine is out of season  Ο No, no reason found |
| If yes or patient already received the vaccine, which vaccine did they receive? | Ο Intramuscular (normal dose)  Ο Intramuscular (high dose)  Ο Intranasal  Ο Intradermal  Ο Unknown |
| Adult smoking history | Ο Current smoker  Ο History of smoking  Ο Non-smoking history |
| If a current smoker, was smoking cessation offered during the current hospitalization? | Ο Yes  Ο No, because the, patient unable to understand  Ο No, because the, patient died  Ο Not applicable, unknown history  Ο No, no reason found |

**COMMENTS**

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