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Data collection form for the project entitled: 'Prevalence of SARS-CoV-2 positivity in infants with bronchiolitis'

Thank you for your participation in the project entitled: 'Prevalence of SARS-CoV-2 positivity in infants with bronchiolitis'. Please complete the data collection form created for the project, after checking the inclusion and exclusion criteria.

Should you encounter any problem with the completion of the questionnaire, please contact Dr. Giangreco Manuela at manuela.giangreco@burlo.trieste.it

Thank you for your cooperation.

id paziente	______________________
Age range: 0 - 12 month	◯ Yes ◯ No (Check for inclusion criteria)
Clinical Diagnosis of bronchiolitis (viral infection - onset with rhinorrhea and/or upper respiratory tract infections followed by respiratory distress associated with: crackles and/or wheezing, use of accessory muscles or lower chest wall retractions, low O2 saturation levels, high respiratory rate relative to age, skin color changes, nasal flaring, fever)	◯ Yes ◯ No (Check for inclusion criteria)
Patient already enrolled in the study	◯ Yes ◯ No (Check for absence of exclusion criteria)
Enrollment center	______________________ (All in lower case with consistent wording)
Date of access to the Pediatric Emergency Department (ED)	______________________ (enter the date in DD/MM/YYYY (day, month and year) format)
Age	______________________ (in months)
Sex	◯ M ◯ F
Weight	______________________ (in kg, decimal separator is period)

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Ethnicity	◯ caucasian ◯ african ◯ asian ◯ other
Specify ethnicity	________________________________ (All in lower case with consistent wording; if possible, do not indicate country of birth or citizenship)
Prematurity: birth before 37 gestational weeks	◯ Yes ◯ No

Comorbidities

Presence of comorbidities	◯ Yes ◯ No
Comorbidity: congenital heart disease	◯ Yes ◯ No
Comorbidity: chronic pulmonary disease	◯ Yes ◯ No
Comorbidity: genetic or malformation syndrome	◯ Yes ◯ No
Specify genetic or malformation syndrome	____ (All in lower case. List all syndromes, separated by commas if more than one)
Comorbidity: Other comorbidity	◯ Yes ◯ No
Specify other comorbidity	____ (All in lower case. List all comorbidities, separated by commas if more than one)

COVID-19 (SARS-CoV-2) positivity

COVID-19 (SARS-CoV-2) positivity	◯ Yes ◯ No
Were any COVID-19 (SARS-CoV-2) diagnostic tests performed?	◯ Yes ◯ No
What type of diagnostic COVID-19 (SARS-CoV-2) tests were performed?	☐ Pharyngeal or nasal swabs, antigenic test ☐ Pharyngeal or nasal swabs, molecular test ☐ Other

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Specify other types of diagnostic COVID-19 (SARS-CoV-2) test performed	__________________ (All in lower case. List all tests, separated by commas if more than one)
COVID-19 (SARS-CoV-2) positivity in parents	◯ Yes ◯ No
Which parent was COVID-19 (SARS-CoV-2) positive?	◯ mother ◯ father ◯ both parents
What type of diagnostic COVID-19 (SARS-CoV-2) tests were performed in parents?	☐ Pharyngeal or nasal swabs, antigenic test ☐ Pharyngeal or nasal swabs, molecular test ☐ Other
Specify other types of diagnostic COVID-19 (SARS-CoV-2) test performed in parents	__________________ (All in lower case. List all tests, separated by commas if more than one)

Diagnostic procedure in the Pediatric ED or during hospitalization

Diagnostic procedure: Blood test	◯ Yes ◯ No
Diagnostic procedure: Chest x-ray	◯ Yes ◯ No
Diagnostic procedure: Chest TC scan	◯ Yes ◯ No
Diagnostic procedure: Serological test for other viruses	◯ Yes ◯ No
Specify positivity to other viruses from serological tests	__________________ (All in lower case. List all positive viruses, separated by commas if more than one)
Diagnostic procedure: Molecular tests for other viruses	◯ Yes ◯ No
Specify positivity to other viruses from molecular tests	__________________ (All in lower case. List all positive viruses, separated by commas if more than one)
Diagnostic procedure: Other procedures performed	◯ Yes ◯ No

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Specify which other diagnostic procedures were performed	__________________________________ (All in lower case. Specify all procedures, separated by commas if more than one)

Medical therapies in the Pediatric ED or during hospitalization

Medical therapy: Hydration / nutritional support (intravenous or feeding tube)	◯ Yes ◯ No
Medical therapy: Oxygen supplementation	◯ Yes ◯ No
Medical therapy: Non-invasive ventilatory support	◯ Yes ◯ No
Which Non-invasive ventilatory support: HFNC (High Flow Nasal Cannula)	◯ Yes ◯ No
Which Non-invasive ventilatory support: C-PAP (Continuous Positive Airway Pressure)	◯ Yes ◯ No
Which Non-invasive ventilatory support: NIV (Non-Invasive Ventilation)	◯ Yes ◯ No
Medical therapy: Mechanical ventilation	◯ Yes ◯ No
Medical therapy: Antibiotic drug	◯ Yes ◯ No
Medical therapy: Salbutamol	◯ Yes ◯ No
Medical therapy: Inhaled corticosteroid drug	◯ Yes ◯ No
Medical therapy: Systemic corticosteroid drug	◯ Yes ◯ No
Medical therapy: Hypertonic solution	◯ Yes ◯ No
Medical therapy: Inhaled adrenaline	◯ Yes ◯ No
Medical therapy: Other drugs	◯ Yes ◯ No
Specify other drugs administered	__________________________________ (All in lower case. Specify all drugs, separated by commas if more than one)

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Outcome - Admission status

Admission status: Discharge	◯ Yes ◯ No
Admission status: Short-Stay Observation (SSO) in the Pediatric ED	◯ Yes ◯ No
Admission status: Admission to the pediatric ward	◯ Yes ◯ No
Admission status: Admission to neonatal intensive care unit	◯ Yes ◯ No
Admission status: Admission to intensive care unit	◯ Yes ◯ No
Admission status: Transferred to another Hospital	◯ Yes ◯ No
Admission status: Other admission status/outcome	◯ Yes ◯ No
Specify other admission status/outcome	______________________ (All in lower case)
Length of hospitalization	______________________ (in numbers)

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