

Appendix 2: Entry form

ENTRY FORM



PLEASE COMPLETE 1-30 BEFORE RANDOMISING THE PATIENT

ABOUT YOUR HOSPITAL (please ensure all information below is contained in the medical records)

1. Country		2. Hospital name, ID	
------------	--	----------------------	--

ABOUT THE PATIENT (circle one answer where options are given)

3. Date of admission to hospital	day	month	year	4. Sex	MALE	FEMALE
5. Age (approximate if unknown)	years			6. Current smoker?	YES	NO

7. COVID-19 status	SUSPECTED		CONFIRMED	NOT SUSPECTED (do not randomise)		
8. Difficulty breathing	YES	NO	9. Signs of hypoxia?		YES	NO
10. Breathing assisted by	NONE	OXYGEN ONLY	CPAP	BIPAP	MECHANICAL VENTILATION (do not randomise)	
11. Chronic respiratory disease	YES	NO	17. Liver disease		YES	NO
12. Cardiovascular disease	YES	NO	18. Cancer		YES	NO
13. Immunocompromised	YES	NO	19. Neurological disease		YES	NO
14. Body mass index >40 (estimated)	YES	NO	20. Current active infection		YES	NO
15. Diabetes mellitus	YES	NO	21. Other major disease		YES	NO
16. Renal failure	YES	NO	a. If Yes, describe			
22. Terminally ill / approaching end of life	YES	NO	If YES, do not randomise			
23. Any clinical indication for or contraindication to aspirin, losartan or statins	YES	NO	If YES, do not randomise			
24. Consent type	PATIENT	PERSONAL REPRESENTATIVE		PROFESSIONAL REPRESENTATIVE		
25. Blood Pressure (mmHg)	a. Systolic	b. Diastolic	26. Temperature (°C)			
27. Heart Rate (beats per minute)			28. Respiratory Rate (breaths per minute)			
29. Chest X ray / Chest CT results	NOT AVAILABLE	NORMAL	PNEUMONIA	OTHER		

30. Eligible? (age ≥ 40, confirmed/suspected acute COVID-19, not pregnant, no contraindication to trial drugs, not on mechanical ventilation and not terminally ill / approaching end of life)	YES	NO	If YES, go online and upload baseline data to randomise					
31. Insert RANDOMISATION number					Record from randomisation screen. Write number in medical records. Prescribe and give intervention(s) immediately after randomisation.			
32. Intervention(s) to be given (for site use only)	ASPIRIN	LOSARTAN	SIMVASTATIN	ASPIRIN + LOSARTAN	ASPIRIN + SIMVASTATIN	LOSARTAN + SIMVASTATIN	ASPIRIN + LOSARTAN + SIMVASTATIN	STANDARD CARE ONLY
33. Date of randomisation	day	month	year	34. Time of randomisation (24-hour clock)		hours	minutes	
35. Name of person randomising	first/last name			36. Signature				
SITE ADMIN - NON TRIAL DATA - USED ONLY FOR IDENTIFYING PATIENT FOR HOSPITAL FOLLOW UP ONLY								
37. PATIENT DETAILS	a) Patient name	first/last name			c) Hospital ID number			
	b) Date of birth	day	month	year	d) Ward admitted to			

CRASH-19 – Entry form Version 1.0 [15 April 2020]

Appendix 3: Outcome form

OUTCOME FORM



PLEASE COMPLETE AT DEATH, DISCHARGE OR DAY 28 WHICHEVER COMES FIRST

1. HOSPITAL NAME, ID																																																					
2. PATIENT RANDOMISATION NUMBER																																																					
3. OUTCOME																																																					
3.1 DEATH IN HOSPITAL				3.2 PATIENT ALIVE <i>(Select one and provide date)</i>																																																	
a) Date of death				a) Still in this hospital now <i>(28 days after randomisation) – Date</i>																																																	
DAY (DD)	MONTH (MM)	YEAR (YYYY)	b) Time of death (24hr)		DAY (DD)	MONTH (MM)	YEAR (YYYY)																																														
			HOUR (HH)	MIN (MM)	b) Transferred to another hospital – Date of discharge																																																
c) Primary Cause of death <i>(tick one option)</i>				c) Discharged home – Date of discharge																																																	
<input type="checkbox"/> Respiratory failure incl. ARDS <input type="checkbox"/> Congestive cardiac failure <input type="checkbox"/> Myocardial infarction <input type="checkbox"/> Sepsis <input type="checkbox"/> Multi organ failure <input type="checkbox"/> Other, describe here (only one) _____				DAY (DD) MONTH (MM) YEAR (YYYY)																																																	
4. MANAGEMENT				3.3 Ability to self-care at discharge versus before illness <i>(circle one):</i>																																																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">a) Admitted to ICU</td> <td style="padding: 5px;">YES</td> <td style="padding: 5px;">NO</td> <td style="padding: 5px;">Needed, not available</td> </tr> <tr> <td colspan="4" style="padding: 5px;">i) if yes, days in ICU (if none, write '0')</td> </tr> <tr> <td style="padding: 5px;">b) Ventilatory support</td> <td style="padding: 5px;">YES</td> <td style="padding: 5px;">NO</td> <td style="padding: 5px;">Needed, not available</td> </tr> <tr> <td colspan="4" style="padding: 5px;">i) Mechanical ventilation</td> </tr> <tr> <td style="padding: 5px;">ii) CPAP/BIPAP</td> <td style="padding: 5px;">YES</td> <td style="padding: 5px;">NO</td> <td style="padding: 5px;">Needed, not available</td> </tr> <tr> <td style="padding: 5px;">c) Corticosteroids</td> <td style="padding: 5px;">YES</td> <td style="padding: 5px;">NO</td> <td rowspan="7" style="padding: 5px;"></td> </tr> <tr> <td style="padding: 5px;">d) Antimalarial</td> <td style="padding: 5px;">YES</td> <td style="padding: 5px;">NO</td> </tr> <tr> <td style="padding: 5px;">e) Antiviral</td> <td style="padding: 5px;">YES</td> <td style="padding: 5px;">NO</td> </tr> <tr> <td style="padding: 5px;">f) Antibiotics</td> <td style="padding: 5px;">YES</td> <td style="padding: 5px;">NO</td> </tr> <tr> <td style="padding: 5px;">g) Vasopressor/inotrope</td> <td style="padding: 5px;">YES</td> <td style="padding: 5px;">NO</td> </tr> </table>				a) Admitted to ICU	YES	NO	Needed, not available	i) if yes, days in ICU (if none, write '0')				b) Ventilatory support	YES	NO	Needed, not available	i) Mechanical ventilation				ii) CPAP/BIPAP	YES	NO	Needed, not available	c) Corticosteroids	YES	NO		d) Antimalarial	YES	NO	e) Antiviral	YES	NO	f) Antibiotics	YES	NO	g) Vasopressor/inotrope	YES	NO	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">SAME AS BEFORE ILLNESS</td> <td style="padding: 5px;">WORSE</td> <td style="padding: 5px;">BETTER</td> </tr> </table>				SAME AS BEFORE ILLNESS	WORSE	BETTER							
a) Admitted to ICU	YES	NO	Needed, not available																																																		
i) if yes, days in ICU (if none, write '0')																																																					
b) Ventilatory support	YES	NO	Needed, not available																																																		
i) Mechanical ventilation																																																					
ii) CPAP/BIPAP	YES	NO	Needed, not available																																																		
c) Corticosteroids	YES	NO																																																			
d) Antimalarial	YES	NO																																																			
e) Antiviral	YES	NO																																																			
f) Antibiotics	YES	NO																																																			
g) Vasopressor/inotrope	YES	NO																																																			
SAME AS BEFORE ILLNESS	WORSE	BETTER																																																			
6. COMPLICATIONS				7. PERSON COMPLETING FORM																																																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">a) Myocardial infarction</td> <td style="padding: 5px;">YES</td> <td style="padding: 5px;">NO</td> </tr> <tr> <td style="padding: 5px;">b) Congestive cardiac failure</td> <td style="padding: 5px;">YES</td> <td style="padding: 5px;">NO</td> </tr> <tr> <td style="padding: 5px;">c) Severe cardiac arrhythmia</td> <td style="padding: 5px;">YES</td> <td style="padding: 5px;">NO</td> </tr> <tr> <td style="padding: 5px;">d) Myocarditis</td> <td style="padding: 5px;">YES</td> <td style="padding: 5px;">NO</td> </tr> <tr> <td style="padding: 5px;">e) Respiratory failure including ARDS</td> <td style="padding: 5px;">YES</td> <td style="padding: 5px;">NO</td> </tr> <tr> <td style="padding: 5px;">f) Viral pneumonitis</td> <td style="padding: 5px;">YES</td> <td style="padding: 5px;">NO</td> </tr> <tr> <td style="padding: 5px;">g) Acute renal failure</td> <td style="padding: 5px;">YES</td> <td style="padding: 5px;">NO</td> </tr> <tr> <td style="padding: 5px;">h) Sepsis</td> <td style="padding: 5px;">YES</td> <td style="padding: 5px;">NO</td> </tr> <tr> <td style="padding: 5px;">i) Stroke</td> <td style="padding: 5px;">YES</td> <td style="padding: 5px;">NO</td> </tr> <tr> <td style="padding: 5px;">j) Gastrointestinal bleeding</td> <td style="padding: 5px;">YES</td> <td style="padding: 5px;">NO</td> </tr> </table>				a) Myocardial infarction	YES	NO	b) Congestive cardiac failure	YES	NO	c) Severe cardiac arrhythmia	YES	NO	d) Myocarditis	YES	NO	e) Respiratory failure including ARDS	YES	NO	f) Viral pneumonitis	YES	NO	g) Acute renal failure	YES	NO	h) Sepsis	YES	NO	i) Stroke	YES	NO	j) Gastrointestinal bleeding	YES	NO	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">a) Name</td> <td colspan="3" style="padding: 5px;"><i>first/last name</i></td> </tr> <tr> <td style="padding: 5px;">b) Job title</td> <td colspan="3" style="padding: 5px;"></td> </tr> <tr> <td style="padding: 5px;">c) Signature</td> <td colspan="3" style="padding: 5px;"></td> </tr> <tr> <td style="padding: 5px;">d) Date</td> <td style="padding: 5px;">DAY (DD)</td> <td style="padding: 5px;">MONTH (MM)</td> <td style="padding: 5px;">YEAR (YYYY)</td> </tr> </table>				a) Name	<i>first/last name</i>			b) Job title				c) Signature				d) Date	DAY (DD)	MONTH (MM)	YEAR (YYYY)
a) Myocardial infarction	YES	NO																																																			
b) Congestive cardiac failure	YES	NO																																																			
c) Severe cardiac arrhythmia	YES	NO																																																			
d) Myocarditis	YES	NO																																																			
e) Respiratory failure including ARDS	YES	NO																																																			
f) Viral pneumonitis	YES	NO																																																			
g) Acute renal failure	YES	NO																																																			
h) Sepsis	YES	NO																																																			
i) Stroke	YES	NO																																																			
j) Gastrointestinal bleeding	YES	NO																																																			
a) Name	<i>first/last name</i>																																																				
b) Job title																																																					
c) Signature																																																					
d) Date	DAY (DD)	MONTH (MM)	YEAR (YYYY)																																																		
5. TRIAL TREATMENT GIVEN				7. PERSON COMPLETING FORM																																																	
<i>if standard care only, skip to Q6</i>			Total number of days																																																		
a) Aspirin 150 mg	YES	NO																																																			
b) Losartan 100 mg	YES	NO																																																			
c) Losartan <100 mg	YES	NO																																																			
d) Simvastatin 80 mg	YES	NO																																																			