Event Checking Chart INFECTION (MoCHiV)
Hospitalization for presumed or proven infection

Please provide DATES as DD/MM/YYYY Date questionnaire filled in:

1. Patient information

Center-ID		**Gender**	
MoCHiV-ID		**Date of birth**	

2. Hospitalization

From:		**To:**	
Hospital		**ICU**	

3. Relevant diagnoses provided in the letter of discharge, provide ICD10 if available

Diagnosis	**ICD-10**

4. Signs & Symptoms

Symptoms	**yes**	**no**	**unk**	
Fever or Hypothermia	☐	☐	☐	**If, yes specify:**
Cough	☐	☐	☐	
Respiratory distress	☐	☐	☐	
Hypotension	☐	☐	☐	
Tachy- or bradycardia	☐	☐	☐	**If, yes specify:**
Diarrhea	☐	☐	☐	
Vomiting	☐	☐	☐	
Irritability	☐	☐	☐	
Other	☐	☐	☐	**If, yes specify:**
Other 1	☐	☐	☐	**If, yes specify:**

5. Microbiology results

Specimen	**Method**	**pos**	**neg**	**NA**	**If positive specify pathogen**
Blood	culture	☐	☐	☐	
CSF	culture	☐	☐	☐	
Urine	culture	☐	☐	☐	
Other:					
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	

6. Maximum CRP (mg/dl): ☐ DATE: ☐

7. Imaging performed and findings

Imaging	yes	no	NA	If yes specify result
Chest x-ray	☐	☐	☐	
Abdomen ultrasound	☐	☐	☐	
Head CT or MRI	☐	☐	☐	
Other	☐	☐	☐	

8. Anti-infective treatment

Agent (active substance)	From (DATE)	To (DATE)	Route (IV, PO, IM)

IV = intravenous, PO = per oral, IM = intramuscular

9. Outcome

☐ complete recovery

☐ residual symptoms specify: ☐

☐ death DATE: ☐

☐ unknown

10. Comments

☐

Please send the form to:

Data Center Swiss HIV Cohort Study
Waltersbachstrasse 5
8006 Zürich

Date: Investigator: Signature: