Txt ARI CRF

Please complete the survey below about [week_0_arm_1][nbcrf_inf_name]'s recent episode of cough and/or fever.

If you have any questions or concerns, please contact a PREVAIL Research Coordinator.

About a week ago, you reported that [week_0_arm_1][nbcrf_inf_name] had a cough and/or fever. Please complete the following survey to tell us more about that illness.

What day did [week_0_arm_1][nbcrf_inf_name] become ill?

_____

Did [week_0_arm_1][nbcrf_inf_name] ever have a fever during this illness?

- ◯ No
- ◯ Yes
- ◯ Unsure/Unknown
- ◯ Refused/No Response

How many days did [week_0_arm_1][nbcrf_inf_name] have a fever?

- ◯ Unsure/Unknown
- ◯ Refused/No Response
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
- ◯ 9
- ◯ 10
- ◯ 11
- ◯ 12
- ◯ 13
- ◯ 14
- ◯ 15
- ◯ 16
- ◯ 17
- ◯ 18
- ◯ 19
- ◯ 20
- ◯ 21
- ◯ 22
- ◯ 23
- ◯ 24
- ◯ 25
- ◯ 26
- ◯ 27
- ◯ 28
- ◯ 29
- ◯ 30
- ◯ 31

What was the highest temperature measured?

_____

Unit of measurement for temperature

- ◯ Fahrenheit
- ◯ Celsius

Temperature Method	◯ Rectal ◯ Armpit ◯ Mouth ◯ Ear ◯ Forehead ◯ Unsure/Unknown ◯ Other

SYMPTOMS

Did [week_0_arm_1][nbcrf_inf_name] have a cough during this illness?	◯ No ◯ Yes ◯ Unsure/Unknown ◯ Refused/ No Response
How many days did [week_0_arm_1][nbcrf_inf_name] have a cough?	◯ Unsure/Unknown ◯ Refused/No Response ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12 ◯ 13 ◯ 14 ◯ 15 ◯ 16 ◯ 17 ◯ 18 ◯ 19 ◯ 20 ◯ 21 ◯ 22 ◯ 23 ◯ 24 ◯ 25 ◯ 26 ◯ 27 ◯ 28 ◯ 29 ◯ 30 ◯ 31
Did [week_0_arm_1][nbcrf_inf_name] cough up mucous or phlegm?	◯ No ◯ Yes ◯ Unknown/ Unsure ◯ Refused/ No Response
Did [week_0_arm_1][nbcrf_inf_name] cough up blood?	◯ No ◯ Yes ◯ Unsure/ Unknown ◯ Refused/ No Response

Did [week_0_arm_1][nbcrf_inf_name] ever vomit right after coughing?

- ◯ No
- ◯ Yes
- ◯ Unsure/Unknown
- ◯ Refused/ No Response

Did [week_0_arm_1][nbcrf_inf_name] have any of the following symptoms during this illness?

	Yes	No	Unsure/Unknown	Refused/No Response
Earache	◯	◯	◯	◯
Nasal congestion or runny nose	◯	◯	◯	◯
Sore throat	◯	◯	◯	◯
Wheezing	◯	◯	◯	◯
Rapid or shallow breathing/shortness of breath (dyspnea)	◯	◯	◯	◯
Chills	◯	◯	◯	◯
Fatigue/weakness	◯	◯	◯	◯
Muscle aches (myalgias)	◯	◯	◯	◯
Headache	◯	◯	◯	◯
Red/pink eye(s) (conjunctivitis)	◯	◯	◯	◯
Loss of appetite/refusal to eat	◯	◯	◯	◯
Abdominal pain	◯	◯	◯	◯
Vomiting (not associated with coughing)	◯	◯	◯	◯
Diarrhea	◯	◯	◯	◯
Listless/lethargic	◯	◯	◯	◯
Confusion	◯	◯	◯	◯
Irritability/fussiness	◯	◯	◯	◯
Seizures	◯	◯	◯	◯
Skin rash	◯	◯	◯	◯
Other	◯	◯	◯	◯

If "other" symptoms, please describe:

_____

Medical Visits

How many times did [week_0_arm_1][nbcrf_inf_name] go to a doctor, clinic, emergency room or hospital during this episode of illness?

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4 or more times

Medical Visit 1

(1) Date of Visit

_____

(1) Date Description	◯ Exact ◯ Approximate ◯ Unknown ◯ No Response/Refused
(1) Location	◯ Doctor's office/Clinic ◯ Emergency room ◯ Admitted to hospital
Medical Visit 2	
(2) Date of Visit	_____
(2) Date Description	◯ Exact ◯ Approximate ◯ Unknown ◯ No Response/Refused
(2) Location	◯ Doctor's office/Clinic ◯ Emergency room ◯ Admitted to hospital
Medical Visit 3	
(3) Date of Visit	_____
(3) Date Description	◯ Exact ◯ Approximate ◯ Unknown ◯ No Response/Refused
(3) Location	◯ Doctor's office/Clinic ◯ Emergency room ◯ Admitted to hospital
A member of the PREVAIL study staff will contact you to discuss [week_0_arm_1][nbcrf_inf_name]'s remaining medical visit/visits	
If [week_0_arm_1][nbcrf_inf_name] has had 4 or more medical visits during this episode of illness, please enter the date, date description, and location here:	_____

MEDICATIONS

Did [week_0_arm_1][nbcrf_inf_name] receive any antibiotics for this illness?	◯ No ◯ Yes ◯ Unsure/Unknown ◯ Refused/No Response

What antibiotics were prescribed for this illness?

	Yes	No	Unsure/Unknown	Refused/No Response
Amoxicillin	◯	◯	◯	◯
Amoxicillin/Clavulanate (Augmentin)	◯	◯	◯	◯
Cefdinir (Omnicef)	◯	◯	◯	◯
Azithromycin (Zithromax)	◯	◯	◯	◯
Clindamycin	◯	◯	◯	◯
Ceftriaxone (Rocephin) (shot)	◯	◯	◯	◯
Levofloxacin (Levaquin)	◯	◯	◯	◯
Other	◯	◯	◯	◯
Unknown	◯	◯	◯	◯

Amoxicillin - Start Date:

_____

Amoxicillin - Date Description:

◯ Exact
◯ Approximate
◯ Unknown
◯ No Response/Refused

Amoxicillin/Clavulanate (Augmentin) - Start Date:

_____

Amoxicillin/Clavulanate (Augmentin) - Date Description:

◯ Exact
◯ Approximate
◯ Unknown
◯ No Response/Refused

Cefdinir (Omnicef) - Start Date

_____

Cefdinir (Omnicef) - Date Description

◯ Exact
◯ Approximate
◯ Unknown
◯ No Response/Refused

Azithromycin (Zithromax) - Start Date

_____

Azithromycin (Zithromax) - Date Description:

◯ Exact
◯ Approximate
◯ Unknown
◯ No Response/Refused

Clindamycin - Start Date:

_____

Clindamycin - Date Description:

◯ Exact
◯ Approximate
◯ Unknown
◯ No Response/Refused

Ceftriaxone (Rocephin) - Date shot administered:

_____

Ceftriaxone (Rocephin) - Date Description:

◯ Exact
◯ Approximate
◯ Unknown
◯ No Response/Refused

Levofloxacin (Levoquin) - Start Date:

_____

Levofloxacin (Levaquin) - Date Description:

◯ Exact
◯ Approximate
◯ Unknown
◯ No Response/Refused

If "Other" antibiotic, please specify the name here:

_____

Other Antibiotic - Start Date:

_____

Other Antibiotic - Date Description:

◯ Exact
◯ Approximate
◯ Unknown
◯ No Response/Refused

Unknown Antibiotic - Start Date:

_____

Unknown Antibiotic - Date Description:

◯ Exact
◯ Approximate
◯ Unknown
◯ No Response/Refused

Will you be able to find out the name of the unknown antibiotic at a later time?

◯ No
◯ Yes

A member of the PREVAIL team will contact you soon to complete the unknown antibiotic information

Did [week_0_arm_1][nbcrf_inf_name] receive any influenza-specific antiviral medications for this illness?

◯ No
◯ Yes
◯ Unsure/Unknown
◯ Refused/No Response

What antivirals were prescribed for this illness?

	Yes	No	Unsure/Unknown	Refused/No Response
Oseltamivir (Generic or Tamiflu)	◯	◯	◯	◯
Other	◯	◯	◯	◯

Unknown	◯	◯	◯	◯

Oseltamivir (generic or Tamiflu), oral - Start Date:

_____

Oseltamivir (generic or Tamiflu), oral - Date Description:

◯ Exact
◯ Approximate
◯ Unknown
◯ No Response/Refused

If "Other" antiviral, please specify the name here:

_____

Other Antiviral - Start Date:

_____

Other Antiviral - Date Description:

◯ Exact
◯ Approximate
◯ Unknown
◯ No Response/Refused

Unknown Antiviral - Start Date:

_____

Unknown Antiviral - Date Description:

◯ Exact
◯ Approximate
◯ Unknown
◯ No Response/Refused

Will you be able to find out the name of the unknown antiviral medication at a later time?

◯ No
◯ Yes

A member of the PREVAIL study staff will contact you within a week to discuss [week_0_arm_1][nbcrf_inf_name]'s antiviral medication

INFANT SLEEP HABITS

On other questionnaires, we have asked you about how your baby sleeps. We are interested in knowing if infants' sleep habits change during illness.
During this illness, in which positions did you lay [week_0_arm_1][nbcrf_inf_name] down to sleep?

	Never	Rarely	Sometimes	Often	Always
On his or her side	◯	◯	◯	◯	◯
On his or her back	◯	◯	◯	◯	◯
On his or her stomach	◯	◯	◯	◯	◯

During this illness, how often has [week_0_arm_1][nbcrf_inf_name] slept alone in his or her own crib or bed?

◯ Never
◯ Rarely
◯ Sometimes
◯ Often
◯ Always

During this illness, who has [week_0_arm_1][nbcrf_inf_name] slept with when he or she is not sleeping alone?

- ☐ Me
- ☐ My Husband or Partner
- ☐ Someone else
- ☐ Not applicable, my child ALWAYS sleeps alone

If [week_0_arm_1][nbcrf_inf_name] sleeps with someone else, please tell us who: _____

During this illness, has your child EVER slept in any of the locations listed below?

Check all that apply

- ☐ In a crib, bassinet, or pack and play
- ☐ On a twin or larger mattress or bed
- ☐ On a couch, sofa or armchair
- ☐ In an infant car seat or swing
- ☐ In a sleeping sack or wearable blanket
- ☐ With a blanket
- ☐ With toys, cushions, or pillows, including nursing pillows
- ☐ With crib bumper pads (mesh or non-mesh)

ARI CASE DEFINITION

An ARI episode is defined as the presence of cough OR fever (temperature 38.0 C/100.4 F, rectal/typannic; 37.0 C/98.6 F, axillary/temporal or 37.3 C/99.5 F oral) at any time in the previous week. An episode of ARI will be considered ended when two or more asymptomatic days have occurred.

STUDY STAFF

Does the child appear to meet ARI case definition?

- ◯ Yes
- ◯ No

If no, why?

_____

STUDY PHYSICIAN

Does the child appear to meet ARI case definition?

- ◯ Yes
- ◯ No

If no, why?

_____