

Stroke Event Report Number        
12000-13990

Subject ID:          
Centre # Community # Household # Member #

Subject Initials      
F M L

Baseline ID:                  
Centre # U/ R Community/Village # Household # Study code / Subject ID #

Follow up Date:          
year month day

Corresponding Follow up Visit: ☐ 1 Year ☐ 2 Year ☐ 3 Year ☐ 4 Year  
☐ 5 Year ☐ 6 Year ☐ 7 Year ☐ 8 Year  
☐ 9 Year ☐ 10 Year ☐ 11 Year ☐ 12 Year  
☐ 13 Year ☐ 14 Year ☐ 15 Year ☐ 16 Year  
☐ 17 Year ☐ 18 Year ☐ 19 Year ☐ 20 Year  
☐ 21 Year **OR** ☐ Reported at time of death

1. Date of Stroke diagnosis:          
year month **OR** ☐ Unk

2. Was subject hospitalized? ☐ No → Reason why: (check ALL that apply); Proceed to Q4 ☐ Yes → Go to Q3

- ☐ a. Event did not need hospitalization  
☐ b. Visited a clinic/medical professional  
☐ c. Visited a traditional healer  
☐ d. Could not get transportation on time  
☐ e. Could not afford transportation  
☐ f. Could not afford hospital care  
☐ g. Other reasons \_\_\_\_\_  
Specify

3. Hospital Details:

i) Date of Admission        
year month

ii) Number of days in hospital:

iii) Number of days off work or usual activities (including hospital stay)

iv) Name of Hospital: \_\_\_\_\_

v) City: \_\_\_\_\_

vi) State/Province: \_\_\_\_\_

vii) Type of Hospital: ☐ Government ☐ Non-government or Private

viii) Mode of transportation to hospital: ☐ Public Transportation ☐ Taxi ☐ Private car ☐ Walk

☐ Other \_\_\_\_\_  
Specify

ix) Was subject transferred to another hospital for further care? ☐ No ☐ Yes

4. Did subject receive any of the following therapies as in-patient or out-patient? (Check ALL that apply)

- ☐ Physiotherapy ☐ Occupational Therapy ☐ Speech and language therapy ☐ Other \_\_\_\_\_  
Specify  
☐ No therapy

5. Did subject receive any of the following treatments:

- ☐ Aspirin ☐ Anticoagulant (e.g. Heparin) ☐ Thrombolysis ☐ Others \_\_\_\_\_  
Specify  
☐ Statin ☐ ACE-Inhibitor ☐ Angiotensin II Receptor Blocker (ARB) ☐ No treatments

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☐ 17 Year ☐ 18 Year ☐ 19 Year ☐ 20 Year  
☐ 21 Year **OR** ☐ Reported at time of death

### 6. SYMPTOMS (at time of presentation)

- a) Did the subject become unconscious or drowsy?  
b) Was there loss of vision?  
c) Was there weakness in face or limbs?  
d) Was there weakness in one limb/half the body?  
e) Was there difficulty in speaking?  
f) Was there a disturbance of balance or walking?  
g) Was there a trauma to the head or neck in the last week?

No	Yes	Unk
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Was duration of any symptoms > 24 hours? ☐ No ☐ Yes ☐ Unknown

8. How long were the symptoms present **before seeking** medical attention?

☐ Minutes  
☐ Hours  
☐ Days  
☐ Weeks  
**OR** ☐ Unk

9. How long did it take to see a physician or nurse?  
(Include **both** waiting time to obtain an appointment and waiting time once at healthcare facility, to see doctor or nurse)

☐ Minutes  
☐ Hours  
☐ Days  
☐ Weeks  
**OR** ☐ Unk

10a. Was CT scan or MRI done to confirm diagnosis? ☐ No ☐ Yes ☐ N/A

10b. Was an autopsy or post-mortem done to confirm diagnosis? ☐ No ☐ Yes ☐ N/A

11. Current Modified-Rankin Scale score for this subject? (see facing page for score):

12. Has subject died? ☐ No ☐ Yes

13. Please make digital copy of available supporting documentation for the subject ☐ **No supporting documents**

☐ Discharge report ☐ Narrative Summary ☐ Physician /Consult notes ☐ Prescription List ☐ Diagnostic test results

☐ Histology/Pathology report ☐ Operative/Surgical Report ☐ Laboratory test results ☐ Electrocardiogram

☐ Death certificate ☐ Autopsy/Post-mortem report ☐ Sputum test results ☐ Biopsy ☐ Echo Report

☐ Test results ☐ CT Scan ☐ MRI ☐ Spirometry report/ Lung function report

☐ Other \_\_\_\_\_  
Specify

Stroke Event  
Report Number

12000-13990

Subject ID:

Centre #		Community #		Household #		Member #	

Subject  
Initials

F	M	L

Baseline ID:

Centre #	U/ R	Community/ Village #		Household #						Study code / Subject ID #					

Corresponding  
Follow up Visit:

- |                                  |  |                                  |                                  |
|----------------------------------|--|----------------------------------|----------------------------------|
| <input type="checkbox"/> 1 Year  | <input type="checkbox"/> 2 Year                              | <input type="checkbox"/> 3 Year  | <input type="checkbox"/> 4 Year  |
| <input type="checkbox"/> 5 Year  | <input type="checkbox"/> 6 Year                              | <input type="checkbox"/> 7 Year  | <input type="checkbox"/> 8 Year  |
| <input type="checkbox"/> 9 Year  | <input type="checkbox"/> 10 Year                             | <input type="checkbox"/> 11 Year | <input type="checkbox"/> 12 Year |
| <input type="checkbox"/> 13 Year | <input type="checkbox"/> 14 Year                             | <input type="checkbox"/> 15 Year | <input type="checkbox"/> 16 Year |
| <input type="checkbox"/> 17 Year | <input type="checkbox"/> 18 Year                             | <input type="checkbox"/> 19 Year | <input type="checkbox"/> 20 Year |
| <input type="checkbox"/> 21 Year | <b>OR</b> <input type="checkbox"/> Reported at time of death |                                  |                                  |

*Note: These details are for tracking purposes only. The fields do not exist in ROME PURE as they are automatically obtained electronically once entered. The field worker who completes the visit must therefore enter the information into ROME PURE.*

Person Completing  
Report:

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*Print last name/first initial*

Date:

year				month		day	

Signature of Investigator:

Date:

year				month		day	

MI Event  
Report Number

10000-19990

Subject ID:

Centre # Community # Household # Member #

Subject  
Initials

F M L

Baseline ID:

Centre # U/ R Community/  
Village # Household # Study code / Subject ID #

Follow up Date:

year month day

Corresponding  
Follow up Visit:

- ☐ 1 Year ☐ 2 Year ☐ 3 Year ☐ 4 Year  
☐ 5 Year ☐ 6 Year ☐ 7 Year ☐ 8 Year  
☐ 9 Year ☐ 10 Year ☐ 11 Year ☐ 12 Year  
☐ 13 Year ☐ 14 Year ☐ 15 Year ☐ 16 Year  
☐ 17 Year ☐ 18 Year ☐ 19 Year ☐ 20 Year  
☐ 21 Year **OR** ☐ Reported at time of death

1. Date of MI diagnosis:

year month

OR ☐ Unk

2. Was subject hospitalized?

☐ No → Reason why: (check all that apply)

☐ Yes → Go to Q3 (i-ix)

- ☐ a. Event did not need hospitalization  
☐ b. Visited a clinic/medical professional  
☐ c. Visited a traditional healer  
☐ d. Could not get transportation on time  
☐ e. Could not afford transportation  
☐ f. Could not afford hospital care  
☐ g. Other reasons \_\_\_\_\_

Specify

3. Hospital Details:

i) Date of Admission

year month

ii) Number of days in hospital:

iii) Number of days off work or  
usual activities (including hospital stay)

iv) Name of Hospital:

v) City:

vi) State/Province:

vii) Type of Hospital:

- ☐ Government  
☐ Non-government/Private

viii) Mode of transportation to hospital: ☐ Public Transportation ☐ Taxi ☐ Private car ☐ Walk

☐ Other \_\_\_\_\_

Specify

ix) Was subject transferred to another hospital for further care?

☐ No ☐ Yes

4. Did the subject have any of the following symptoms:

- a) Chest pain or discomfort >20 mins ☐ No ☐ Yes ☐ Unknown  
b) Pain radiating to arm, shoulder or neck ☐ No ☐ Yes ☐ Unknown  
c) Sweating or vomiting ☐ No ☐ Yes ☐ Unknown  
d) Others ☐ No ☐ Yes → \_\_\_\_\_

Specify

MI Event  
Report Number

10000-19990

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Centre # Community # Household # Member #

Subject  
Initials

F M L

Baseline ID:

Centre # U/ R Community/  
Village # Household # Study code / Subject ID #

Corresponding  
Follow up Visit:

- ☐ 1 Year ☐ 2 Year ☐ 3 Year ☐ 4 Year  
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☐ 9 Year ☐ 10 Year ☐ 11 Year ☐ 12 Year  
☐ 13 Year ☐ 14 Year ☐ 15 Year ☐ 16 Year  
☐ 17 Year ☐ 18 Year ☐ 19 Year ☐ 20 Year  
☐ 21 Year **OR** ☐ Reported at time of death

5. How long were the symptoms present **before**  
seeking medical attention?

Minutes  
Hours  
Days  
Weeks

OR → Unk

6. How long did it take to see a physician or nurse?  
(Include both waiting time to obtain an appointment and  
waiting time once at healthcare facility, to see doctor or nurse)

Minutes  
Hours  
Days  
Weeks

OR → Unk

7. Were any blood tests done? ☐ No ☐ Yes ☐ Not Available8. Has subject died? ☐ No ☐ Yes

9. Has the participant received:

i) Thrombolytic therapy ☐ No ☐ Yes ☐ Unk  
 ii) PCI ☐ No ☐ Yes ☐ Unk  
 iii) CABG Surgery ☐ No ☐ Yes ☐ Unk

10. Were any of the following medications used to treat MI? (Select from list below)

OR → ☐ No drugs ☐ Unk

☐ ASA ☐ Statin ☐ ACE-Inhibitor ☐ Nitrates (IV or oral) ☐ Calcium channel blocker  
☐ Prasugrel ☐ Angiotensin II Receptor Blocker (ARB) ☐ Ticagrelor ☐ Plavix  
☐ Beta-blockers  
☐ Other \_\_\_\_\_  
 Specify

11. Please make digital copy of available supporting documentation for the subject

☐ No supporting documents

☐ Discharge report ☐ Narrative Summary ☐ Physician /Consult notes ☐ Prescription List ☐ Diagnostic test results  
☐ Histology/Pathology report ☐ Operative/Surgical Report ☐ Laboratory test results ☐ Electrocardiogram  
☐ Death certificate ☐ Autopsy/Post-mortem report ☐ Sputum test results ☐ Biopsy ☐ Echo Report  
☐ Test results ☐ CT Scan ☐ MRI ☐ Spirometry report/ Lung function report  
☐ Other \_\_\_\_\_  
 Specify

MI Event  
Report Number

10000-19990

Subject ID:

Centre #		Community #		Household #		Member #			

Subject  
Initials

F	M	L

Baseline ID:

Centre #	U/ R	Community/ Village #		Household #						Study code / Subject ID #							

Corresponding  
Follow up Visit:

<input type="checkbox"/> 1 Year	<input type="checkbox"/> 2 Year	<input type="checkbox"/> 3 Year	<input type="checkbox"/> 4 Year
<input type="checkbox"/> 5 Year	<input type="checkbox"/> 6 Year	<input type="checkbox"/> 7 Year	<input type="checkbox"/> 8 Year
<input type="checkbox"/> 9 Year	<input type="checkbox"/> 10 Year	<input type="checkbox"/> 11 Year	<input type="checkbox"/> 12 Year
<input type="checkbox"/> 13 Year	<input type="checkbox"/> 14 Year	<input type="checkbox"/> 15 Year	<input type="checkbox"/> 16 Year
<input type="checkbox"/> 17 Year	<input type="checkbox"/> 18 Year	<input type="checkbox"/> 19 Year	<input type="checkbox"/> 20 Year
<input type="checkbox"/> 21 Year	<b>OR</b> <input type="checkbox"/> Reported at time of death		

**These question(s) are to be answered by the Site Coordinator**12. Were cardiac enzymes measured? ☐ Not Sure ☐ No ☐ Yes → Indicate measured enzymes below

<input type="checkbox"/> CK
<input type="checkbox"/> CK-MB
<input type="checkbox"/> LDH
<input type="checkbox"/> AST
<input type="checkbox"/> Troponin T
<input type="checkbox"/> Troponin I

a. Were the enzymes 2 x ULN?

☐ No ☐ Yes ☐ Unknown
b. Were these above the **local laboratory** threshold to diagnose MI?
☐ No ☐ Yes ☐ Unknown
13. Was ECG done? ☐ No ☐ Yes → (Check ALL that apply below) ☐ ECG Unavailable

	No	Yes
i) Q waves	<input type="checkbox"/>	<input type="checkbox"/>
ii) ST elevation	<input type="checkbox"/>	<input type="checkbox"/>
iii) ST depression ≥ 2 mm	<input type="checkbox"/>	<input type="checkbox"/>
iv) T inversion ≥ 3 mm	<input type="checkbox"/>	<input type="checkbox"/>
v) New bundle branch	<input type="checkbox"/>	<input type="checkbox"/>

Note: These details are for tracking purposes only. The fields do not exist in ROME PURE as they are automatically obtained electronically once entered. The field worked who completes the visit must therefore enter the information into ROME PURE.

Person Completing  
Report:

Print last name/first initial

Date:

year				month		day	

Signature of Investigator:

Date:

year				month		day	

Heart Failure Event  
Report Number

14000-15990

Subject ID:

Centre # Community # Household # Member #

Subject  
Initials

F M L

Baseline ID:

Centre # U/R Community/Village # Household # Study code / Subject ID #

Follow up Date:

year month day

Corresponding  
Follow up Visit:

- ☐ 1 Year ☐ 2 Year ☐ 3 Year ☐ 4 Year  
☐ 5 Year ☐ 6 Year ☐ 7 Year ☐ 8 Year  
☐ 9 Year ☐ 10 Year ☐ 11 Year ☐ 12 Year  
☐ 13 Year ☐ 14 Year ☐ 15 Year ☐ 16 Year  
☐ 17 Year ☐ 18 Year ☐ 19 Year ☐ 20 Year  
☐ 21 Year **OR** ☐ Reported at time of death

1. Date of Heart Failure diagnosis:

year month

**OR** ☐ Unknown date of diagnosis

1a. Was this related to COVID-19?

☐ No ☐ Yes

2. Was subject hospitalized?

☐ No → Reason why: (check **ALL** that apply);  
Proceed to Q4

☐ Yes → Go to Q3

- ☐ a. Event did not need hospitalization  
☐ b. Visited a clinic/medical professional  
☐ c. Visited a traditional healer  
☐ d. Could not get transportation on time  
☐ e. Could not afford transportation  
☐ f. Could not afford hospital care  
☐ g. Other reasons \_\_\_\_\_  
 Specify

3. Hospital Details:

i. Date of Admission

year month

ii. Number of days in hospital:

iii. Number of days off work or  
usual activities (including hospital stay)

iv. Name of Hospital: \_\_\_\_\_

v. City: \_\_\_\_\_

vi. State/Province: \_\_\_\_\_

vii. Type of Hospital: ☐ Government ☐ Non-government  
or Privateviii. Mode of transportation to hospital: ☐ Public Transportation ☐ Taxi ☐ Private car ☐ Walk

☐ Other \_\_\_\_\_  
Specify

ix. Was subject transferred to another hospital for further care?

☐ No ☐ Yes

4. Did he/she experience any symptoms?

☐ No → Go to Q7 ☐ Yes → Complete a) - e) below

a. Shortness of breath

☐ No ☐ Yes

→ i. During exertion

No Yes

☐ ☐

b. Awaken during sleep  
by shortness of breath

☐ No ☐ Yes

ii. At rest

☐ ☐

c. Swelling of feet

☐ No ☐ Yes

d. Wheezing

☐ No ☐ Yes

e. Other

☐ No ☐ Yes

→ \_\_\_\_\_  
Specify

Heart Failure Event  
Report Number

14000-15990

Subject ID:

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Subject  
Initials

F	M	L

Baseline ID:

Centre #		U/ R		Community/ Village #		Household #						Study code / Subject ID #					

Corresponding  
Follow up Visit:

- ☐ 1 Year   ☐ 2 Year   ☐ 3 Year   ☐ 4 Year  
☐ 5 Year   ☐ 6 Year   ☐ 7 Year   ☐ 8 Year  
☐ 9 Year   ☐ 10 Year   ☐ 11 Year   ☐ 12 Year  
☐ 13 Year   ☐ 14 Year   ☐ 15 Year   ☐ 16 Year  
☐ 17 Year   ☐ 18 Year   ☐ 19 Year   ☐ 20 Year  
☐ 21 Year   **OR** ☐ Reported at time of death

5. How long were the symptoms present **before seeking** medical attention?

--	--	--

- ☐ Minutes  
☐ Hours  
☐ Days  
☐ Weeks

OR → **Unk**  
☐6. How long did it take to see a physician or nurse?  
(Include both waiting time to obtain an appointment and waiting time once at healthcare facility, to see doctor or nurse)

--	--	--

- ☐ Minutes  
☐ Hours  
☐ Days  
☐ Weeks

OR → **Unk**  
☐

7. Did the subject have any of the following accompanying this event?

Did this precede the heart failure event?

	No	Yes	→	No	Yes	
a) Pneumonia/respiratory infection	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	
b) Other Infections	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	Specify Site
c) MI	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	
d) Anemia	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	
e) Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	
f) Other precipitating cause	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	Specify
g) Mechanical ventilation	<input type="checkbox"/>	<input type="checkbox"/>				
h) Angina	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	

8. Did the subject have an assessment of LV function?

☐ No   ☐ Yesa. What method was used? ☐ Nuclear studies   ☐ Echo   ☐ Angio☐ Other \_\_\_\_\_  
Specifyb. Was there documentation of low ejection fraction  
(either an EF below 40% or a statement that EF was reduced)?☐ No   ☐ Yes → ☐ EF was below 40%☐ EF was between 41-50%☐ EF was greater than 50%



Heart Failure Event  
Report Number

14000-15990

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Subject  
Initials

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Baseline ID:

Centre #	U/ R	Community/ Village #		Household #						Study code / Subject ID #					

Corresponding  
Follow up Visit:

- ☐ 1 Year   ☐ 2 Year   ☐ 3 Year   ☐ 4 Year  
☐ 5 Year   ☐ 6 Year   ☐ 7 Year   ☐ 8 Year  
☐ 9 Year   ☐ 10 Year   ☐ 11 Year   ☐ 12 Year  
☐ 13 Year   ☐ 14 Year   ☐ 15 Year   ☐ 16 Year  
☐ 17 Year   ☐ 18 Year   ☐ 19 Year   ☐ 20 Year  
☐ 21 Year   **OR** ☐ Reported at time of death

9. Were any of the following medications used to treat heart failure? *Select from list below***OR** ☐ No drugs   ☐ Unk

- ☐ Diuretics   ☐ Digitalis   ☐ ACE-Inhibitor   ☐ Nitrates (IV or oral)   ☐ IV Inotropes (dobutamine, dopamine)   ☐ Beta-blockers  
☐ Entresto (Sacubitril/Valsartain)   ☐ Spironolactone   ☐ Angiotensin II Receptor Blocker (ARB)  
☐ Other \_\_\_\_\_  
Specify

10. Has subject died?

☐ No   ☐ Yes

11. Please make digital copy of available supporting documentation for the subject

☐ **No supporting documents**

- ☐ Discharge report   ☐ Narrative Summary   ☐ Physician /Consult notes   ☐ Prescription List   ☐ Diagnostic test results  
☐ Histology/Pathology report   ☐ Operative/Surgical Report   ☐ Laboratory test results   ☐ Electrocardiogram  
☐ Death certificate   ☐ Autopsy/Post-mortem report   ☐ Sputum test results   ☐ Biopsy   ☐ Echo Report  
☐ Test results   ☐ CT Scan   ☐ MRI   ☐ Spirometry report/ Lung function report  
☐ Other \_\_\_\_\_  
Specify

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Person Completing  
Report:\_\_\_\_\_  
*Print last name/first initial*

Date:

year				month		day	

Signature of Investigator: \_\_\_\_\_

Date:

year				month		day	

Cancer Event Report Number   
16000-17990

Subject ID:   
Centre # Community # Household # Member #

Subject Initials   
F M L

Baseline ID:   
Centre # U/R Community/Village # Household # Study code / Subject ID #

Follow up Date:   
year month day

Corresponding Follow up Visit: ☐ 1 Year ☐ 2 Year ☐ 3 Year ☐ 4 Year  
☐ 5 Year ☐ 6 Year ☐ 7 Year ☐ 8 Year  
☐ 9 Year ☐ 10 Year ☐ 11 Year ☐ 12 Year  
☐ 13 Year ☐ 14 Year ☐ 15 Year ☐ 16 Year  
☐ 17 Year ☐ 18 Year ☐ 19 Year ☐ 20 Year  
☐ 21 Year **OR** ☐ Reported at time of death

1. Cancer diagnosis: ☐ Newly diagnosed cancer  
☐ Recurrence of same cancer, previously diagnosed

i) Date of **Original** cancer diagnosis, by physician:

year month **OR** ☐ Unk

2. Date of diagnosis of **NEW** cancer or **Recurrent** cancer, by physician:

year month **OR** ☐ Unk

3. Cancer site:  → Please refer to facing page for cancer site codes

3a. If Code 16: \_\_\_\_\_  
Specify

4. Cancer type: ☐ Local ☐ Regional ☐ Metastasis

Please refer to facing page for type definitions and cancer site codes

If code 15  → , ,   
Specify Sites  
If code 16 ↓

\_\_\_\_\_  
Specify

\_\_\_\_\_  
Specify

5. Was subject hospitalized? ☐ No → Reason why: (check **ALL** that apply); go to Q7 ☐ Yes

☐ a. Managed as outpatient by a medical professional

☐ b. Visited a traditional healer

☐ c. Could not afford transportation

☐ d. Could not afford hospital care

☐ e. Other reasons \_\_\_\_\_  
Specify

6. Hospital Details:

i) Date of Admission   
year month

ii) Number of days in hospital:

iii) Name of Hospital: \_\_\_\_\_

iv) City: \_\_\_\_\_

v) State/Province: \_\_\_\_\_

vi) Type of Hospital: ☐ Government  
☐ Non-government/Private

7. Did subject stop working because of cancer and treatments? ☐ No ☐ Yes → ☐ Temporary  
☐ Permanent

☐ Not applicable

7a(i). If temporary, how long?   
☐ Days ☐ Weeks ☐ Months

Cancer Event  
Report Number

16000-17990

Subject ID:

Centre #		Community #		Household #		Member #

Subject  
Initials

F	M	L

Baseline ID:

Centre #		U/R	Community/ Village #		Household #						Study code / Subject ID #					

Corresponding  
Follow up Visit:

<input type="checkbox"/> 1 Year	<input type="checkbox"/> 2 Year	<input type="checkbox"/> 3 Year	<input type="checkbox"/> 4 Year
<input type="checkbox"/> 5 Year	<input type="checkbox"/> 6 Year	<input type="checkbox"/> 7 Year	<input type="checkbox"/> 8 Year
<input type="checkbox"/> 9 Year	<input type="checkbox"/> 10 Year	<input type="checkbox"/> 11 Year	<input type="checkbox"/> 12 Year
<input type="checkbox"/> 13 Year	<input type="checkbox"/> 14 Year	<input type="checkbox"/> 15 Year	<input type="checkbox"/> 16 Year
<input type="checkbox"/> 17 Year	<input type="checkbox"/> 18 Year	<input type="checkbox"/> 19 Year	<input type="checkbox"/> 20 Year
<input type="checkbox"/> 21 Year	<b>OR</b> <input type="checkbox"/> Reported at time of death		

8. Did the subject receive treatment for this diagnosis of cancer? **A response to 8(a-f) below is required.**

	No	Yes	Unk
a. Surgery for removal of the cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Palliative therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Hormonal therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Alternative therapy (see facing page for codes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If YES →

Alternative Therapy Code(s)

		,			,		
--	--	---	--	--	---	--	--

If Code 99:

Specify

9. Has this cancer been confirmed histologically? ☐ No → **Go to Q10**  
*Please refer to facing page for definitions*☐ Yes → **Provide details in 9a and b**

a. Please specify Histologic/Pathologic type: \_\_\_\_\_

b. Please specify the method of diagnosis below:

	No	Yes
i) Histology/Pathology report	<input type="checkbox"/>	<input type="checkbox"/>
ii) Operative/Surgical report	<input type="checkbox"/>	<input type="checkbox"/>
iii) Physician note/narrative	<input type="checkbox"/>	<input type="checkbox"/>
iv) Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Specify

10. Has this cancer been confirmed by any of the following methods of diagnosis? ☐ No ☐ Yes → **Please specify the method(s) of diagnosis:**

	No	Yes
i) CT scan/MRI/PET scan/bone scan	<input type="checkbox"/>	<input type="checkbox"/>
ii) Bronchoscopy/endoscopy	<input type="checkbox"/>	<input type="checkbox"/>
iii) Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>
iv) Laboratory tests	<input type="checkbox"/>	<input type="checkbox"/>
v) X-Ray	<input type="checkbox"/>	<input type="checkbox"/>
vi) Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Specify

11. Has subject died? ☐ No ☐ Yes

12. Please make digital copy of available supporting documentation for the subject ☐ **No supporting documents**

☐ Discharge report ☐ Narrative Summary ☐ Physician /Consult notes ☐ Prescription List ☐ Diagnostic test results

☐ Histology/Pathology report ☐ Operative/Surgical Report ☐ Laboratory test results ☐ Electrocardiogram

☐ Death certificate ☐ Autopsy/Post-mortem report ☐ Sputum test results ☐ Biopsy ☐ Echo Report

☐ Test results ☐ CT Scan ☐ MRI ☐ Spirometry report/ Lung function report

☐ Other \_\_\_\_\_  
Specify

*Note: These details are for tracking purposes only. The fields do not exist in ROME PURE as they are automatically obtained electronically once entered. The field worked who completes the visit must therefore enter the information into ROME PURE.*

Person Completing Report: \_\_\_\_\_  
Print last name/first initial

Date: 

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year month day

Signature of Investigator: \_\_\_\_\_

Date: 

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year month day

**August 3, 2022 Version 9.0 FINAL**



AFib Event  
Report Number   
35000-36990

Subject ID:       
Centre # Community # Household # Member #

Subject  
Initials   
F M L

Baseline ID:     
Centre # U/ R Community/Village # Household # Study code / Subject ID #

Follow up Date:     
year month day

Corresponding  
Follow up Visit: ☐ 1 Year ☐ 2 Year ☐ 3 Year ☐ 4 Year  
☐ 5 Year ☐ 6 Year ☐ 7 Year ☐ 8 Year  
☐ 9 Year ☐ 10 Year ☐ 11 Year ☐ 12 Year  
☐ 13 Year ☐ 14 Year ☐ 15 Year ☐ 16 Year  
☐ 17 Year ☐ 18 Year ☐ 19 Year ☐ 20 Year  
☐ 21 Year **OR** ☐ Reported at time of death

1. Was the participant diagnosed with: ☐ Atrial Fibrillation  
☐ Atrial Flutter

2. Diagnosis Type: ☐ Newly diagnosed  
☐ Recurrent episode

i) Date of **Original** diagnosis

year month

**OR** ☐ Unk

3. Date of diagnosis of **NEW** atrial fibrillation/flutter or **RECURRENT** episode of atrial fibrillation/flutter after initial diagnosis

year month

**OR** ☐ Unk

4. Was subject hospitalized? ☐ No → Reason why: (check **all** that apply)

☐ Yes →    
year month

i) Admission Date:

- ☐ a. Event did not need hospitalization  
☐ b. Visited a clinic/medical professional  
☐ c. Visited a traditional healer  
☐ d. Could not get transportation on time  
☐ e. Could not afford transportation  
☐ f. Could not afford hospital care  
☐ g. Other reasons \_\_\_\_\_

Specify

ii) Number of days in hospital:

iii) Number of days off work or usual activities (including hospital stay)

AFib Event  
Report Number

35000-36990

Subject ID:

Centre #		Community #		Household #		Member #				

Subject  
Initials

F	M	L

Baseline ID:

Centre #	U/ R	Community/ Village #		Household #						Study code / Subject ID #							

Corresponding  
Follow up Visit:

<input type="checkbox"/> 1 Year	<input type="checkbox"/> 2 Year	<input type="checkbox"/> 3 Year	<input type="checkbox"/> 4 Year
<input type="checkbox"/> 5 Year	<input type="checkbox"/> 6 Year	<input type="checkbox"/> 7 Year	<input type="checkbox"/> 8 Year
<input type="checkbox"/> 9 Year	<input type="checkbox"/> 10 Year	<input type="checkbox"/> 11 Year	<input type="checkbox"/> 12 Year
<input type="checkbox"/> 13 Year	<input type="checkbox"/> 14 Year	<input type="checkbox"/> 15 Year	<input type="checkbox"/> 16 Year
<input type="checkbox"/> 17 Year	<input type="checkbox"/> 18 Year	<input type="checkbox"/> 19 Year	<input type="checkbox"/> 20 Year
<input type="checkbox"/> 21 Year	<b>OR</b> <input type="checkbox"/> Reported at time of death		

5. Did the subject experience a stroke within the month before: ☐ No ☐ Yes ☐ Unknown

6. Did the subject experience any of the following symptoms:

a) Shortness of breath	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
b) Chest pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
c) Palpitations	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
d) Dizziness or loss of consciousness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

7. How long were the symptoms present **before seeking** medical attention?

--	--	--

☐ Minutes  
☐ Hours  
☐ Days  
☐ Weeks

**OR** → **Unk**  
☐

8. How long did it take to see a physician or nurse?  
*(Include both waiting time to obtain an appointment and waiting time once at healthcare facility, to see doctor or nurse)*

--	--	--

☐ Minutes  
☐ Hours  
☐ Days  
☐ Weeks

**OR** → **Unk**  
☐

9. Was the subject **electrically** cardioverted (*a shock to return the heart to regular rhythm*)?

☐ No ☐ Yes

☐ Unknown

10. Did the heart rhythm return to normal?

☐ No ☐ Yes → (*answer i and ii below*)

☐ Unknown

i) Was it after cardioversion?

☐ No ☐ Yes

☐ Unknown

ii) Was it spontaneously?

☐ No ☐ Yes → *After how many days?*

No. of days

--	--	--

☐ Unknown



AFib Event  
Report Number

35000-36990

Subject ID:

Centre #		Community #		Household #		Member #			

Subject  
Initials

F	M	L

Baseline ID:

Centre #		U/ R	Community/ Village #		Household #						Study code / Subject ID #						

Corresponding  
Follow up Visit:

- |                                  |  |                                  |                                  |
|----------------------------------|--|----------------------------------|----------------------------------|
| <input type="checkbox"/> 1 Year  | <input type="checkbox"/> 2 Year                              | <input type="checkbox"/> 3 Year  | <input type="checkbox"/> 4 Year  |
| <input type="checkbox"/> 5 Year  | <input type="checkbox"/> 6 Year                              | <input type="checkbox"/> 7 Year  | <input type="checkbox"/> 8 Year  |
| <input type="checkbox"/> 9 Year  | <input type="checkbox"/> 10 Year                             | <input type="checkbox"/> 11 Year | <input type="checkbox"/> 12 Year |
| <input type="checkbox"/> 13 Year | <input type="checkbox"/> 14 Year                             | <input type="checkbox"/> 15 Year | <input type="checkbox"/> 16 Year |
| <input type="checkbox"/> 17 Year | <input type="checkbox"/> 18 Year                             | <input type="checkbox"/> 19 Year | <input type="checkbox"/> 20 Year |
| <input type="checkbox"/> 21 Year | <b>OR</b> <input type="checkbox"/> Reported at time of death |                                  |                                  |

11. Were any of the following medications used to treat atrial fibrillation/flutter?  
(Select from list below)

**OR** ☐ No drugs ☐ Unk

- |  |   |                                     |                                      |                                     |
|--|---|-------------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Calcium channel blocker | <input type="checkbox"/> Beta-blocker           | <input type="checkbox"/> Dabigatran | <input type="checkbox"/> Apixaban    | <input type="checkbox"/> Amiodarone |
| <input type="checkbox"/> Digitalis               | <input type="checkbox"/> Warfarin<br>(Coumadin) | <input type="checkbox"/> Aspirin    | <input type="checkbox"/> Clopidogrel | <input type="checkbox"/> Sotalol    |
| <input type="checkbox"/> Edoxaban                | <input type="checkbox"/> Rivaroxiban            | <input type="checkbox"/> Other      | Specify _____                        |                                     |

12. Has subject died? ☐ No ☐ Yes

13. Please make digital copy of available supporting documentation for the subject ☐ **No supporting documents**

- |   |   |   |  |  |
|---|---|---|--|--|
| <input type="checkbox"/> Discharge report           | <input type="checkbox"/> Narrative Summary          | <input type="checkbox"/> Physician /Consult notes | <input type="checkbox"/> Prescription List                       | <input type="checkbox"/> Diagnostic test results |
| <input type="checkbox"/> Histology/Pathology report | <input type="checkbox"/> Operative/Surgical Report  | <input type="checkbox"/> Laboratory test results  | <input type="checkbox"/> Electrocardiogram                       |  |
| <input type="checkbox"/> Death certificate          | <input type="checkbox"/> Autopsy/Post-mortem report | <input type="checkbox"/> Sputum test results      | <input type="checkbox"/> Biopsy                                  | <input type="checkbox"/> Echo Report             |
| <input type="checkbox"/> Test results               | <input type="checkbox"/> CT Scan                    | <input type="checkbox"/> MRI                      | <input type="checkbox"/> Spirometry report/ Lung function report |  |
| <input type="checkbox"/> Other                      | Specify _____                                       |   |  |  |

Note: These details are for tracking purposes only. The fields do not exist in ROME PURE as they are automatically obtained electronically once entered. The field worked who completes the visit must therefore enter the information into ROME PURE.

Person Completing  
Report:

Print last name/first initial

Date:

year				month		day	

Signature of Investigator:

Date:

year				month		day	

Angina Event  
Report Number

33000-34990

Subject ID:

Centre #		Community #		Household #		Member #	

Subject  
Initials

F	M	L

Baseline ID:

Centre #		U/ R	Community/ Village #		Household #						Study code / Subject ID #						

Follow up Date:

year			month		day	

Corresponding  
Follow up Visit:

<input type="checkbox"/> 1 Year	<input type="checkbox"/> 2 Year	<input type="checkbox"/> 3 Year	<input type="checkbox"/> 4 Year
<input type="checkbox"/> 5 Year	<input type="checkbox"/> 6 Year	<input type="checkbox"/> 7 Year	<input type="checkbox"/> 8 Year
<input type="checkbox"/> 9 Year	<input type="checkbox"/> 10 Year	<input type="checkbox"/> 11 Year	<input type="checkbox"/> 12 Year
<input type="checkbox"/> 13 Year	<input type="checkbox"/> 14 Year	<input type="checkbox"/> 15 Year	<input type="checkbox"/> 16 Year
<input type="checkbox"/> 17 Year	<input type="checkbox"/> 18 Year	<input type="checkbox"/> 19 Year	<input type="checkbox"/> 20 Year
<input type="checkbox"/> 21 Year	<b>OR</b> <input type="checkbox"/> Reported at time of death		

1. Angina diagnosis: ☐ New Diagnosis ☐ Worsening angina ☐ Unstable angina2. If **Worsening** or **Unstable** only: i) Date of **Original** angina diagnosis:

year			month		

OR ☐ Unk

No Yes Unk

ii. Increased frequency

☐ ☐ ☐

iii. Increased severity

☐ ☐ ☐

iv. Increased duration

☐ ☐ ☐3. Date of diagnosis of **NEW** angina or date of **worsening/unstable** angina, after initial diagnosis

year			month		

OR ☐ Unk4. Was subject hospitalized? ☐ No → Reason why: (check **all** that apply)☐ Yes →

year			month		

i. Admission Date:

☐ a. Event did not need hospitalization☐ b. Visited a clinic/medical professional☐ c. Visited a traditional healer☐ d. Could not get transportation on time☐ e. Could not afford transportation☐ f. Could not afford hospital care☐ g. Other reasons \_\_\_\_\_  
Specify

ii) Number of days in hospital:

--	--	--

iii) Number of days off work or  
usual activities (**including hospital stay**)

--	--	--

5. Were the following tests performed?

a) ECG/Stress test

No Yes Unk

☐ ☐ ☐

b) Stress Echocardiogram

☐ ☐ ☐

c) Blood test

☐ ☐ ☐

If YES, evidence of ischemia?

No Yes Unk

☐ ☐ ☐☐ ☐ ☐☐ ☐ ☐6. Did the subject have a coronary angiography performed? ☐ No ☐ Yes ☐ Unknown7. Did the subject have CABG surgery? ☐ No ☐ Yes ☐ Unknown8. Did the subject have PCI/PTCA? ☐ No ☐ Yes ☐ Unknown

Angina Event  
Report Number

33000-34990

Subject ID:

Centre #		Community #		Household #		Member #	

Subject  
Initials

F	M	L

Baseline ID:

Centre #		U/ R	Community/ Village #		Household #						Study code / Subject ID #						

Corresponding  
Follow up Visit:

- |                                  |  |                                  |                                  |
|----------------------------------|--|----------------------------------|----------------------------------|
| <input type="checkbox"/> 1 Year  | <input type="checkbox"/> 2 Year                              | <input type="checkbox"/> 3 Year  | <input type="checkbox"/> 4 Year  |
| <input type="checkbox"/> 5 Year  | <input type="checkbox"/> 6 Year                              | <input type="checkbox"/> 7 Year  | <input type="checkbox"/> 8 Year  |
| <input type="checkbox"/> 9 Year  | <input type="checkbox"/> 10 Year                             | <input type="checkbox"/> 11 Year | <input type="checkbox"/> 12 Year |
| <input type="checkbox"/> 13 Year | <input type="checkbox"/> 14 Year                             | <input type="checkbox"/> 15 Year | <input type="checkbox"/> 16 Year |
| <input type="checkbox"/> 17 Year | <input type="checkbox"/> 18 Year                             | <input type="checkbox"/> 19 Year | <input type="checkbox"/> 20 Year |
| <input type="checkbox"/> 21 Year | <b>OR</b> <input type="checkbox"/> Reported at time of death |                                  |                                  |

9. Were any of the following medications used to treat Angina? (Select from list below)

**OR** ☐ No drugs ☐ Unk
☐ Aspirin    ☐ Beta-blocker    ☐ Clopidogrel    ☐ Nitrates    ☐ Ticlopidine

☐ Statin    ☐ Calcium Channel Blockers    ☐ Other \_\_\_\_\_  
Specify
10. Has subject died? ☐ No ☐ Yes11. Please make digital copy of available supporting documentation for the subject ☐ **No supporting documents**

- |   |   |   |  |  |
|---|---|---|--|--|
| <input type="checkbox"/> Discharge report           | <input type="checkbox"/> Narrative Summary          | <input type="checkbox"/> Physician /Consult notes | <input type="checkbox"/> Prescription List                       | <input type="checkbox"/> Diagnostic test results |
| <input type="checkbox"/> Histology/Pathology report | <input type="checkbox"/> Operative/Surgical Report  | <input type="checkbox"/> Laboratory test results  | <input type="checkbox"/> Electrocardiogram                       |  |
| <input type="checkbox"/> Death certificate          | <input type="checkbox"/> Autopsy/Post-mortem report | <input type="checkbox"/> Sputum test results      | <input type="checkbox"/> Biopsy                                  | <input type="checkbox"/> Echo Report             |
| <input type="checkbox"/> Test results               | <input type="checkbox"/> CT Scan                    | <input type="checkbox"/> MRI                      | <input type="checkbox"/> Spirometry report/ Lung function report |  |
| <input type="checkbox"/> Other _____<br>Specify     |   |   |  |  |

**These question(s) are to be answered by a medically qualified person only**12. New ECG changes? ☐ Not available ☐ No ☐ Yes → If Yes, please indicate changes below:

	No	Yes	Unk
a) ST depression $\geq 0.5$ mm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) T-wave inversion $\geq 2$ mm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Transient ST elevation of $\geq 1$ mm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Other ECG changes _____ Specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Note: These details are for tracking purposes only. The fields do not exist in ROME PURE as they are automatically obtained electronically once entered. The field worked who completes the visit must therefore enter the information into ROME PURE.*

Person Completing  
Report:\_\_\_\_\_  
Print last name/first initial

Date:

year				month		day	

Signature of Investigator: \_\_\_\_\_

Date:

year				month		day	

Subject ID:

Centre #		Community #		Household #		Member #	

Subject  
Initials

F	M	L

Baseline ID:

Centre #	U/ R	Community/ Village #		Household #						Study code / Subject ID #					

Follow up Date:

year				month		day	

Corresponding  
Follow up Visit:

<input type="checkbox"/> 1 Year	<input type="checkbox"/> 2 Year	<input type="checkbox"/> 3 Year	<input type="checkbox"/> 4 Year
<input type="checkbox"/> 5 Year	<input type="checkbox"/> 6 Year	<input type="checkbox"/> 7 Year	<input type="checkbox"/> 8 Year
<input type="checkbox"/> 9 Year	<input type="checkbox"/> 10 Year	<input type="checkbox"/> 11 Year	<input type="checkbox"/> 12 Year
<input type="checkbox"/> 13 Year	<input type="checkbox"/> 14 Year	<input type="checkbox"/> 15 Year	<input type="checkbox"/> 16 Year
<input type="checkbox"/> 17 Year	<input type="checkbox"/> 18 Year	<input type="checkbox"/> 19 Year	<input type="checkbox"/> 20 Year
<input type="checkbox"/> 21 Year	<b>OR</b> <input type="checkbox"/> Reported at time of death		

1. Date of Asthma diagnosis:

year				month	

**OR** ☐ Unk

i. Admission Date:

year				month	

2. Was subject hospitalized?

☐ No → Reason why (check **all** that apply)☐ Yes →

- ☐ a. Event did not need hospitalization
- ☐ b. Visited a clinic/ medical professional
- ☐ c. Visited a traditional healer
- ☐ d. Could not get transportation on time
- ☐ e. Could not afford transportation
- ☐ f. Could not afford hospital care
- ☐ g. Other reasons \_\_\_\_\_

Specify

ii) Number of days in hospital: 

--	--	--

iii) Number of days off work or usual activities (**including hospital stay**) 

--	--	--

3. Symptoms (at time of presentation)

No Yes Unk

a) Wheezing

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

b) Shortness of breath

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

c) Tightness in the chest

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

4. Spirometry abnormal

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

5. Diagnosis by methacholine challenge test

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

6. Therapy with bronchodilators, including inhaled steroids

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

7. Were any of the following medications used to treat Asthma? (Select from list below)

- |   |  |   |                                      |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Albuterol (Salbutamol) | <input type="checkbox"/> Bambuterol          | <input type="checkbox"/> Beclomethasone | <input type="checkbox"/> Bitolterol  |
| <input type="checkbox"/> Budesonide             | <input type="checkbox"/> Doxofylline         | <input type="checkbox"/> Ephedrine      | <input type="checkbox"/> Fluticasone |
| <input type="checkbox"/> Hydrocortisone         | <input type="checkbox"/> Ipratropium Bromide | <input type="checkbox"/> Metaproterenol | <input type="checkbox"/> Prednisone  |
| <input type="checkbox"/> Other _____            |  |   |                                      |

Specify

**OR** → ☐ No drugs ☐ Unk

8. Has subject died?

☐ No ☐ Yes

9. Please make digital copy of available supporting documentation for the subject

☐ **No supporting documents**

☐ Discharge report ☐ Narrative Summary ☐ Physician /Consult notes ☐ Prescription List ☐ Diagnostic test results

☐ Histology/Pathology report ☐ Operative/Surgical Report ☐ Laboratory test results ☐ Electrocardiogram

☐ Death certificate ☐ Autopsy/Post-mortem report ☐ Sputum test results ☐ Biopsy ☐ Echo Report

☐ Test results ☐ CT Scan ☐ MRI ☐ Spirometry report/ Lung function report

☐ Other \_\_\_\_\_  
Specify

*Note: These details are for tracking purposes only. The fields do not exist in ROME PURE as they are automatically obtained electronically once entered. The field worked who completes the visit must therefore enter the information into ROME PURE.*

Person Completing  
Report: \_\_\_\_\_  
Print last name/first initial

Date: 

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--	--

  
year month day

Signature of Investigator: \_\_\_\_\_

Date: 

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--	--

--	--

  
year month day

Subject ID:

Centre #		Community #		Household #		Member #	

Subject Initials

F	M	L

Baseline ID:

Centre #		U/ R	Community/ Village #		Household #						Study code / Subject ID #					

Follow up Date:

year				month		day

Corresponding Follow up Visit:

<input type="checkbox"/> 1 Year	<input type="checkbox"/> 2 Year	<input type="checkbox"/> 3 Year	<input type="checkbox"/> 4 Year
<input type="checkbox"/> 5 Year	<input type="checkbox"/> 6 Year	<input type="checkbox"/> 7 Year	<input type="checkbox"/> 8 Year
<input type="checkbox"/> 9 Year	<input type="checkbox"/> 10 Year	<input type="checkbox"/> 11 Year	<input type="checkbox"/> 12 Year
<input type="checkbox"/> 13 Year	<input type="checkbox"/> 14 Year	<input type="checkbox"/> 15 Year	<input type="checkbox"/> 16 Year
<input type="checkbox"/> 17 Year	<input type="checkbox"/> 18 Year	<input type="checkbox"/> 19 Year	<input type="checkbox"/> 20 Year
<input type="checkbox"/> 21 Year	<b>OR</b> <input type="checkbox"/> Reported at time of death		

1. Date of COPD/Chronic Bronchitis/  
Emphysema diagnosis:

year				month	

**OR** ☐ Unk

2. Was subject hospitalized?

☐No → Reason why (check **all** that apply)☐

Yes →

i) Admission Date:

year				month	

☐ a. Event did not need hospitalization☐ b. Visited a clinic/medical professional☐ c. Visited a traditional healer☐ d. Could not get transportation on time☐ e. Could not afford transportation☐ f. Could not afford hospital care☐ g. Other reasons

Specify

ii) Number of days in hospital:

--	--	--

iii) Number of days off work or  
usual activities (**including hospital stay**)

--	--	--

3. Signs/Symptoms (at time of presentation)

No Yes Unk

a) Cough with sputum for at least 3 months for the last 2 years

--	--	--

b) Is the subject on intermittent or daily oxygen treatment

--	--	--

c) Is there difficulty of breathing with walking

--	--	--

d) Is there intermittent or daily wheezing

--	--	--

e) Is there intermittent or daily use of inhalers

--	--	--

4. Spirometry abnormal

--	--	--

5. Diagnosis by methacholine challenge test

--	--	--

6. Therapy with bronchodilators, including inhaled steroids

--	--	--

7. Were any of the following medications used to treat COPD? (Select from list below)

**OR** → ☐ No drugs ☐ Unk☐ Ipratropium (Atrovent)☐ Tiotropium (Spiriva)☐ Salmeterol (Serevent)☐ Formoterol (Foradil)☐ Beclomethasone (Qvar)☐ Fluticasone (Flovent)☐ Ciclesonide (Alvesco)☐ Flunisolide (Aerobid)☐ Mometasone (Asmanex)☐ Triamcinolone (Azmacort)☐ Budesonide (Pulmicort)☐ Other

Specify

8. Has subject died?

☐ No☐ Yes

9. Please make digital copy of available supporting documentation for the subject

☐ **No supporting documents**

☐ Discharge report ☐ Narrative Summary ☐ Physician /Consult notes ☐ Prescription List ☐ Diagnostic test results

☐ Histology/Pathology report ☐ Operative/Surgical Report ☐ Laboratory test results ☐ Electrocardiogram

☐ Death certificate ☐ Autopsy/Post-mortem report ☐ Sputum test results ☐ Biopsy ☐ Echo Report

☐ Test results ☐ CT Scan ☐ MRI ☐ Spirometry report/ Lung function report

☐ Other \_\_\_\_\_  
Specify

Note: These details are for tracking purposes only. The fields do not exist in ROME PURE as they are automatically obtained electronically once entered. The field worked who completes the visit must therefore enter the information into ROME PURE.

Person Completing  
Report: \_\_\_\_\_  
Print last name/first initial

Date: 

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--	--

--	--

  
year month day

Signature of Investigator: \_\_\_\_\_

Date: 

--	--	--	--

--	--

--	--

  
year month day

Subject ID:

Centre #		Community #		Household #		Member #	

Subject  
Initials

F	M	L

Baseline  
ID:

Centre #		U/ R	Community/ Village #		Household #						Study code / Subject ID #					

Follow up Date:

year		month		day		

Corresponding  
Follow up Visit:

<input type="checkbox"/> 3 Year	<input type="checkbox"/> 6 Year	<input type="checkbox"/> 9 Year	<input type="checkbox"/> 12 Year
<input type="checkbox"/> 15 Year	<input type="checkbox"/> 18 Year	<input type="checkbox"/> 21 Year	

1. Date of diagnosis of diabetes:

year		month		day		

OR ☐ Unk

2. How is the diabetes being treated?

- ☐ Life-style therapy alone → **Complete fasting glucose test and record results below**
- ☐ Medication - Specify all of the following anti-diabetic medications the participant is taking:

- ☐ Insulin
- ☐ Thiazolidinediones (e.g. rosiglitazone, pioglitazone)
- ☐ Biguanides (e.g. metformin hydrochloride)
- ☐ Meglitinides (e.g. repaglinide, nateglinide)
- ☐ Sulfonylurea (e.g. acetohexamide, chlorpropamide, gliclazide, glyburide, tolbutamide, glipizide, glimepiride)
- ☐ Alpha-glucosidase inhibitor (e.g. acarbose, miglitol)
- ☐ Other \_\_\_\_\_  
Specify

3. Please record the blood glucose levels supporting the diagnosis. →

Keep a copy of the documentation  
in the subject's file.

a) Date of Glucose Test

year		month		day		

b) Glucose Results:

--	--	--	--

☐ mM/L  
☐ mg/dL

- ☐ Fasting
- ☐ 2 hour OGTT
- ☐ Random
- ☐ Post Prandial Blood Sugar (PPBS)

4. Are HbA1c or Glycated Hemoglobin levels available? ☐ No ☐ Yes → Record results below

a) Date of Test:

year		month		day		

b) Test Results:

percent		fraction			

Note: These details are for tracking purposes only. The fields do not exist in ROME PURE as they are automatically obtained electronically once entered. The field worked who completes the visit must therefore enter the information into ROME PURE.

Person Completing  
Report:\_\_\_\_\_  
Print last name/first initial

Date:

year		month		day		

Signature of Investigator: \_\_\_\_\_

Date:

year		month		day		



Subject ID:

Centre #		Community #		Household #		Member #	

Subject  
Initials

F	M	L

Baseline ID:

Centre #		U/ R	Community/ Village #		Household #						Study code / Subject ID #				

Follow up Date:

year				month		day	

Corresponding  
Follow up Visit:

<input type="checkbox"/> 1 Year	<input type="checkbox"/> 2 Year	<input type="checkbox"/> 3 Year	<input type="checkbox"/> 4 Year
<input type="checkbox"/> 5 Year	<input type="checkbox"/> 6 Year	<input type="checkbox"/> 7 Year	<input type="checkbox"/> 8 Year
<input type="checkbox"/> 9 Year	<input type="checkbox"/> 10 Year	<input type="checkbox"/> 11 Year	<input type="checkbox"/> 12 Year
<input type="checkbox"/> 13 Year	<input type="checkbox"/> 14 Year	<input type="checkbox"/> 15 Year	<input type="checkbox"/> 16 Year
<input type="checkbox"/> 17 Year	<input type="checkbox"/> 18 Year	<input type="checkbox"/> 19 Year	<input type="checkbox"/> 20 Year
<input type="checkbox"/> 21 Year	<b>OR</b> <input type="checkbox"/> Reported at time of death		

1. Date of HIV/AIDS infection  
diagnosis:

year				month	

**OR** ☐ Unk

2. Was subject hospitalized?

☐

No

→ Reason why (check **all** that apply)☐

Yes

i) Admission Date:

year				month	

- ☐ a. Event did not need hospitalization
- ☐ b. Visited a clinic/medical professional
- ☐ c. Visited a traditional healer
- ☐ d. Could not get transportation on time
- ☐ e. Could not afford transportation
- ☐ f. Could not afford hospital care
- ☐ g. Other reasons \_\_\_\_\_

Specify

ii) Number of days in hospital:

--	--	--

iii) Number of days off work or  
usual activities (**including hospital stay**)

--	--	--

3. Signs/Symptoms (**at time of presentation**)

- a) History of severe weight loss in less than 3 months
- b) History of prolonged unexplained fever/diarrhoea
- c) Persistent cough for >1 month
- d) Mouth sores/white patches in mouth
- e) Skin rash
- f) Generalized swelling of nodes in armpits, neck, groin
- g) History of ulcers in genital area
- h) History of spouse/partner with similar illness
- i) Death of spouse/partner from HIV/AIDS

No Yes Unk

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Positive serology

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

5. Did the subject receive treatment for HIV? ☐ No drugs ☐ Yes ☐ Unknown

6. Has subject died? ☐ No ☐ Yes

7. Please make digital copy of available supporting documentation for the subject ☐ **No supporting documents**

☐ Discharge report ☐ Narrative Summary ☐ Physician /Consult notes ☐ Prescription List ☐ Diagnostic test results

☐ Histology/Pathology report ☐ Operative/Surgical Report ☐ Laboratory test results ☐ Electrocardiogram

☐ Death certificate ☐ Autopsy/Post-mortem report ☐ Sputum test results ☐ Biopsy ☐ Echo Report

☐ Test results ☐ CT Scan ☐ MRI ☐ Spirometry report/ Lung function report

☐ Other \_\_\_\_\_  
Specify

*Note: These details are for tracking purposes only. The fields do not exist in ROME PURE as they are automatically obtained electronically once entered. The field worked who completes the visit must therefore enter the information into ROME PURE.*

Person Completing Report: \_\_\_\_\_  
Print last name/first initial

Date: 

year			

month	

day	

Signature of Investigator: \_\_\_\_\_

Date: 

year			

month	

day	

Hospitalization Event  
Report Number

28000-32000

Subject ID:

Centre #		Community #		Household #		Member #	

Subject  
Initials

F	M	L

Baseline ID:

Centre #		U/ R	Community/ Village #		Household #						Study code / Subject ID #						

Follow up Date:

year				month		day	

Corresponding  
Follow up Visit:

- ☐ 1 Year    ☐ 2 Year    ☐ 3 Year    ☐ 4 Year  
☐ 5 Year    ☐ 6 Year    ☐ 7 Year    ☐ 8 Year  
☐ 9 Year    ☐ 10 Year    ☐ 11 Year    ☐ 12 Year  
☐ 13 Year    ☐ 14 Year    ☐ 15 Year    ☐ 16 Year  
☐ 17 Year    ☐ 18 Year    ☐ 19 Year    ☐ 20 Year  
☐ 21 Year    **OR** ☐ Reported at time of death

1. Admission Date:

year				month	

**OR** ☐ Unk

2. Number of days in hospital

--	--	--

3. Name of Hospital:

4. City:

5. State/Province:

6. Type of Hospital:

- ☐ Government  
☐ Non-government/Private

7. Was participant transferred to another hospital for further care?

☐ No    ☐ Yes

8. Reason(s) for admission, procedures and diagnoses that occurred. (Check ALL that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> 01 Typhoid and paratyphoid fevers   | <input type="checkbox"/> 02 Diarrhoea and Gastroenteritis/ Dysentery |
| <input type="checkbox"/> 03 Peptic Ulcer Disease   | <input type="checkbox"/> 04 Appendicitis                             |
| <input type="checkbox"/> 05 Paralytic ileus and intestinal obstruction without hernia                                  | <input type="checkbox"/> 06 Inguinal or femoral hernia               |
| <input type="checkbox"/> 07 Non-infective inflammatory bowel disease (e.g. Crohn's Disease, Ulcerative Colitis, other) | <input type="checkbox"/> 08 Gallbladder and bile duct disease        |
| <input type="checkbox"/> 09 Pancreatitis   | <input type="checkbox"/> 10 Related to normal pregnancy              |
|  | <input type="checkbox"/> 11 Related to pregnancy complications       |
| <input type="checkbox"/> 12 Thromboembolism  | <input type="checkbox"/> 13 Hypertension (High blood pressure)       |
| <input type="checkbox"/> 14 Other digestive diseases or Procedures   | Specify _____  |
| <input type="checkbox"/> 15 Other Heart Conditions or Procedures   | Specify _____  |
| <input type="checkbox"/> 16 Other Lung Conditions or Procedures  | Specify _____  |
| <input type="checkbox"/> 17 Other Conditions or Procedures 1   | Specify _____  |
| <input type="checkbox"/> 18 Other Conditions or Procedures 2   | Specify _____  |
| <input type="checkbox"/> 19 Related to COVID-19  |  |

9. State which of the above was the **primary** reason for hospitalization (enter number)

--	--

11. Has subject died? ☐ No ☐ Yes

12. Please make digital copy of available supporting documentation for the subject ☐ **No supporting documents**

☐ Discharge report ☐ Narrative Summary ☐ Physician /Consult notes ☐ Prescription List ☐ Diagnostic test results

☐ Histology/Pathology report ☐ Operative/Surgical Report ☐ Laboratory test results ☐ Electrocardiogram

☐ Death certificate ☐ Autopsy/Post-mortem report ☐ Sputum test results ☐ Biopsy ☐ Echo Report

☐ Test results ☐ CT Scan ☐ MRI ☐ Spirometry report/ Lung function report

☐ Other \_\_\_\_\_  
Specify

*Note: These details are for tracking purposes only. The fields do not exist in ROME PURE as they are automatically obtained electronically once entered. The field worked who completes the visit must therefore enter the information into ROME PURE.*

Person Completing  
Report: \_\_\_\_\_  
Print last name/first initial

Date: 

year			

month	

day	

Signature of Investigator: \_\_\_\_\_

Date: 

year			

month	

day	

Subject ID:

Centre #		Community #		Household #		Member #			

Subject  
Initials

F	M	L

Baseline ID:

Centre #		U/ R	Community/ Village #		Household #								Study code / Subject ID #							

Follow up Date:

year				month		day	

Corresponding  
Follow up Visit:

<input type="checkbox"/> 1 Year	<input type="checkbox"/> 2 Year	<input type="checkbox"/> 3 Year	<input type="checkbox"/> 4 Year
<input type="checkbox"/> 5 Year	<input type="checkbox"/> 6 Year	<input type="checkbox"/> 7 Year	<input type="checkbox"/> 8 Year
<input type="checkbox"/> 9 Year	<input type="checkbox"/> 10 Year	<input type="checkbox"/> 11 Year	<input type="checkbox"/> 12 Year
<input type="checkbox"/> 13 Year	<input type="checkbox"/> 14 Year	<input type="checkbox"/> 15 Year	<input type="checkbox"/> 16 Year
<input type="checkbox"/> 17 Year	<input type="checkbox"/> 18 Year	<input type="checkbox"/> 19 Year	<input type="checkbox"/> 20 Year
<input type="checkbox"/> 21 Year	<b>OR</b> <input type="checkbox"/> Reported at time of death		

1. Date of IBD diagnosis:

year				month	

**OR** ☐ Unk2. Was the subject diagnosed with:  
diagnosis:

<input type="checkbox"/> Crohn's Disease	→ <b>Complete Q3a and Q3b.</b>
<input type="checkbox"/> Ulcerative Colitis	→ <b>Complete Q4a and Q4b.</b>

3a. Crohn's Disease Site (**Check ALL that apply**):

<input type="checkbox"/> Ileum	<input type="checkbox"/> Colon	<input type="checkbox"/> Ileocolonic	<input type="checkbox"/> Proximal GI Tract (i.e. esophagus to jejunum)	<input type="checkbox"/> Don't Know
--------------------------------	--------------------------------	--------------------------------------	---	-------------------------------------

3b. How was the subject's Crohn's Disease diagnosed?

**OR** → ☐ Don't Know

<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Endoscopy	<input type="checkbox"/> Capsule Endoscopy	<input type="checkbox"/> Imaging Tests (e.g. MRI or CT-scan)	<input type="checkbox"/> Other _____ Specify
--------------------------------------	------------------------------------	---	---	---

4a. Ulcerative Colitis Site (**Check ALL that apply**):

<input type="checkbox"/> Rectal disease	<input type="checkbox"/> Left-sided disease	<input type="checkbox"/> Extensive Colitis (including right colon)	<input type="checkbox"/> Don't Know
--	--	---	-------------------------------------

4b. How was the subject's Ulcerative Colitis diagnosed?

**OR** → ☐ Don't Know

<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Flexible Sigmoidoscopy	<input type="checkbox"/> Other _____ Specify
--------------------------------------	---	---

i. Admission Date:

5. Was subject hospitalized?

<input type="checkbox"/> No → Reason why: (check <b>all</b> that apply)	<input type="checkbox"/> Yes →						
		year				month	

- ☐ a. Event did not need hospitalization
- ☐ b. Visited a clinic/ medical professional
- ☐ c. Visited a traditional healer
- ☐ d. Could not get transportation on time
- ☐ e. Could not afford transportation
- ☐ f. Could not afford hospital care
- ☐ g. Other reasons \_\_\_\_\_  
Specify

ii) Number of days in hospital: 

--	--	--

iii) Number of days off work or  
usual activities (**including hospital stay**) 

--	--	--

6. Did the subject have imaging testing done? (If yes, select from list below) ☐ No ☐ Yes ☐ Don't Know

☐ CT scan ☐ MRI scan ☐ Ultrasound ☐ Other \_\_\_\_\_  
Specify

7. How long were the symptoms present **before seeking** medical attention?

☐ Days  
☐ Weeks  
☐ Months  
☐ Years

OR → **Unk**  
☐

8. Were any of the following medications used to treat IBD? (Select from list below)

OR → ☐ No drugs ☐ Unk

☐ Vedolizumab ☐ Ustekinumab ☐ Tofacitinib ☐ Anti-TNF therapies (e.g. infliximab, adalimumab, golimumab, certolizumab) ☐ 5-ASA Drugs (e.g. mesalamine sulfasalazine)

☐ Immunomodulators (e.g. azathioprine, 6-mercaptopurine, methotrexate) ☐ Corticosteroids (prednisone, prednisolone, budesonide, hydrocortisone)

☐ Other \_\_\_\_\_  
Specify

9. Please make digital copy of available supporting documentation for the subject

☐ **No supporting documents**

☐ Discharge report ☐ Narrative Summary ☐ Physician /Consult notes ☐ Prescription List ☐ Diagnostic test results

☐ Histology/Pathology report ☐ Operative/Surgical Report ☐ Laboratory test results ☐ Electrocardiogram

☐ Death certificate ☐ Autopsy/Post-mortem report ☐ Sputum test results ☐ Biopsy ☐ Echo Report

☐ Test results ☐ CT Scan ☐ MRI ☐ Spirometry report/ Lung function report

☐ Other \_\_\_\_\_  
Specify

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Person Completing  
Report:

\_\_\_\_\_  
Print last name/first initial

Date:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
year			month		day	

Signature of Investigator:

Date:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
year			month		day	

Injury Event  
Report Number

24000-27000

Subject ID:

Centre #		Community #		Household #		Member #	

Subject Initials

F	M	L

Baseline ID:

Centre #	U/ R	Community/ Village #		Household #				Study code / Subject ID #							

Follow up Date:

year				month		day	

Corresponding  
Follow up Visit:

- ☐ 1 Year   ☐ 2 Year   ☐ 3 Year   ☐ 4 Year  
☐ 5 Year   ☐ 6 Year   ☐ 7 Year   ☐ 8 Year  
☐ 9 Year   ☐ 10 Year   ☐ 11 Year   ☐ 12 Year  
☐ 13 Year   ☐ 14 Year   ☐ 15 Year   ☐ 16 Year  
☐ 17 Year   ☐ 18 Year   ☐ 19 Year   ☐ 20 Year  
☐ 21 Year   **OR** ☐ Reported at time of death

1. Date of incident:

year				month	

OR ☐ Unk

2. Time of the incident:

		:		
(00:00-23:59)				

Record the best  
estimate of time  
of incidence

3. Was subject hospitalized?

☐No → Reason why (check **all** that apply)☐

Yes →

i) Admission Date:

year				month	

- ☐ a. Event did not need hospitalization  
☐ b. Visited a clinic/medical professional  
☐ c. Visited a traditional healer  
☐ d. Could not get transportation on time  
☐ e. Could not afford transportation  
☐ f. Could not afford hospital care  
☐ g. Other reasons \_\_\_\_\_  
Specify

ii) Number of days in hospital:

--	--	--

iii) Number of days off work or  
usual activities (**including hospital stay**)

--	--	--

4. Intention: (check one only)

☐

Unintentional (accidental)

☐

Intentional

☐

Undetermined/ Unsure

5. Mechanism of Injury:

--	--

If Code 21:

\_\_\_\_\_

Specify

If code 01 or 02: provide details in question 5a-c below:

5a. What type of vehicle was the member  
travelling in, at the time of the injury?☐

Car

☐

Two-wheeler (motorized)

☐

Bicycle (non-motorized)

☐

Truck

☐

Bus

☐

Other \_\_\_\_\_

Specify

5b. As a driver/passenger of a car or truck, was the individual  
wearing a seatbelt at the time of the injury?☐

No

☐

Yes

☐

NA

☐

Unk

5c. As a driver/passenger of a two-wheeler, was the individual  
wearing a helmet at the time of the injury?☐

No

☐

Yes

☐

NA

☐

Unk

6. Location of Injury:

--	--

If Code 13:

\_\_\_\_\_

Specify

Injury Event  
Report Number

24000-27000

Subject ID:

Centre #		Community #		Household #		Member #	

Subject Initials

F	M	L

Baseline ID:

Centre #	U/ R	Community/ Village #		Household #						Study code / Subject ID #					

Corresponding  
Follow up Visit:

<input type="checkbox"/> 1 Year	<input type="checkbox"/> 2 Year	<input type="checkbox"/> 3 Year	<input type="checkbox"/> 4 Year
<input type="checkbox"/> 5 Year	<input type="checkbox"/> 6 Year	<input type="checkbox"/> 7 Year	<input type="checkbox"/> 8 Year
<input type="checkbox"/> 9 Year	<input type="checkbox"/> 10 Year	<input type="checkbox"/> 11 Year	<input type="checkbox"/> 12 Year
<input type="checkbox"/> 13 Year	<input type="checkbox"/> 14 Year	<input type="checkbox"/> 15 Year	<input type="checkbox"/> 16 Year
<input type="checkbox"/> 17 Year	<input type="checkbox"/> 18 Year	<input type="checkbox"/> 19 Year	<input type="checkbox"/> 20 Year
<input type="checkbox"/> 21 Year	<b>OR</b> <input type="checkbox"/> Reported at time of death		

7. Nature of Injury:

--	--	--	--	--	--

If Code 10:

Specify

If Code 1, please specify Fracture site:

<input type="checkbox"/> Hip	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Upper leg	<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot	<input type="checkbox"/> Lower leg	<input type="checkbox"/> Toes
<input type="checkbox"/> Pelvis	<input type="checkbox"/> Wrist	<input type="checkbox"/> Hand	<input type="checkbox"/> Vertebra	<input type="checkbox"/> Rib	<input type="checkbox"/> Upper arm	
<input type="checkbox"/> Forearm	<input type="checkbox"/> Finger	<input type="checkbox"/> Spine	<input type="checkbox"/> Sternum	<input type="checkbox"/> Others	Specify	

8. Major body part  
Injured:

--	--	--	--	--	--

If Code 8:

Specify

9. Activity at time of incident:

--	--

If Code 9:

Specify

10. Treatment received:

--	--

11. Whether alcohol was a factor?

☐ No ☐ Yes☐ Suspected☐ Confirmed12. Whether any other psychoactive  
substance was a factor?☐ No ☐ Yes☐ Suspected☐ Confirmed☐ Legal☐ Illegal

13. Has subject died?

☐ No☐ Yes

14. Please make digital copy of available supporting documentation for the subject

☐ **No supporting documents**

<input type="checkbox"/> Discharge report	<input type="checkbox"/> Narrative Summary	<input type="checkbox"/> Physician /Consult notes	<input type="checkbox"/> Prescription List	<input type="checkbox"/> Diagnostic test results
<input type="checkbox"/> Histology/Pathology report	<input type="checkbox"/> Operative/Surgical Report	<input type="checkbox"/> Laboratory test results	<input type="checkbox"/> Electrocardiogram	
<input type="checkbox"/> Death certificate	<input type="checkbox"/> Autopsy/Post-mortem report	<input type="checkbox"/> Sputum test results	<input type="checkbox"/> Biopsy	<input type="checkbox"/> Echo Report
<input type="checkbox"/> Test results	<input type="checkbox"/> CT Scan	<input type="checkbox"/> MRI	<input type="checkbox"/> Spirometry report/ Lung function report	
<input type="checkbox"/> Other	Specify			

*Note: These details are for tracking purposes only. The fields do not exist in ROME PURE as they are automatically obtained electronically once entered. The field worked who completes the visit must therefore enter the information into ROME PURE.*

Person Completing  
Report:

Print last name/first initial

Date:

year		month		day			

Signature of Investigator:

Date:

year		month		day			



Kidney Event  
Report Number   
37000-38990

Subject ID:   
Centre # Community # Household # Member #

Subject  
Initials   
F M L

Baseline ID:   
Centre # U/ R Community/  
Village # Household # Study code / Subject ID #

Follow up Date:   
year month day

Corresponding  
Follow up Visit: ☐ 1 Year ☐ 2 Year ☐ 3 Year ☐ 4 Year  
☐ 5 Year ☐ 6 Year ☐ 7 Year ☐ 8 Year  
☐ 9 Year ☐ 10 Year ☐ 11 Year ☐ 12 Year  
☐ 13 Year ☐ 14 Year ☐ 15 Year ☐ 16 Year  
☐ 17 Year ☐ 18 Year ☐ 19 Year ☐ 20 Year  
☐ 21 Year **OR** ☐ Reported at time of death

1. Was a renal transplant done? ☐ No ☐ Yes →   
year month **OR** ☐ Unk

2. Was dialysis required? ☐ No ☐ Yes →   
year month **OR** ☐ Unk

↳ 2a. Was dialysis recommended by a physician but not completed by participant (i.e. participant refused)? ☐ No ☐ Yes

3. Was kidney failure diagnosed? ☐ No ☐ Yes →   
year month **OR** ☐ Unk

↳ 3a. Was this related to COVID-19? ☐ No ☐ Yes

4. Reason(s) for transplant or dialysis:

	No	Yes	Unk	
a) Specific renal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES → <input type="checkbox"/> Glomerulonephritis
b) Severe infection of the kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hypertension
c) Post-surgery or trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
d) Volume depletion (e.g. diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other _____ Specify
e) Volume overload (excess body fluid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f) Hyperkalemia (high potassium in blood)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g) Drug related kidney damage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES → <input type="checkbox"/> NSAID
				<input type="checkbox"/> Contrast media
				<input type="checkbox"/> Other _____ Specify
h) Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES → _____ Specify

5. Was subject hospitalized? ☐ No → Reason why: (check **all** that apply) ☐ Yes →

i) Admission Date: 

year				month	

☐ a. Event did not need hospitalization

☐ b. Visited a clinic/medical professional

☐ c. Visited a traditional healer

☐ d. Could not get transportation on time

☐ e. Could not afford transportation

☐ f. Could not afford hospital care

☐ g. Other reasons \_\_\_\_\_  
Specify

ii) Number of days in hospital: 

--	--	--

iii) Number of days off work or usual activities (**including hospital stay**): 

--	--	--

6. How long was dialysis required for? ☐ < 3 Months ☐ ≥ 3 Months ☐ Unknown

7. If stopped, reasons for stopping dialysis:

☐ Recovery of kidney functions (did not need it anymore) ☐ Transplant ☐ Care withdrawn ☐ Unknown **OR** ☐ Still on dialysis

8. Did participant have known kidney disease before the episode when transplant/dialysis was required? ☐ No ☐ Yes ☐ Unknown

9. Has subject died? ☐ No ☐ Yes

10. Please make digital copy of available supporting documentation for the subject ☐ **No supporting documents**

- ☐ Discharge report ☐ Narrative Summary ☐ Physician /Consult notes ☐ Prescription List ☐ Diagnostic test results
- ☐ Histology/Pathology report ☐ Operative/Surgical Report ☐ Laboratory test results ☐ Electrocardiogram
- ☐ Death certificate ☐ Autopsy/Post-mortem report ☐ Sputum test results ☐ Biopsy ☐ Echo Report
- ☐ Test results ☐ CT Scan ☐ MRI ☐ Spirometry report/ Lung function report
- ☐ Other \_\_\_\_\_  
Specify

*Note: These details are for tracking purposes only. The fields do not exist in ROME PURE as they are automatically obtained electronically once entered. The field worked who completes the visit must therefore enter the information into ROME PURE.*

Person Completing Report: \_\_\_\_\_  
Print last name/first initial

Date: 

year				month	

day	

Signature of Investigator: \_\_\_\_\_

Date: 

year				month	

day	

Malaria Event Report Number   
20000-21990

Subject ID:   
Centre # Community # Household # Member #

Subject Initials   
F M L

Baseline ID:   
Centre # U/ R Community/ Village # Household # Study code / Subject ID #

Follow up Date:   
year month day

Corresponding Follow up Visit: ☐ 1 Year ☐ 2 Year ☐ 3 Year ☐ 4 Year  
☐ 5 Year ☐ 6 Year ☐ 7 Year ☐ 8 Year  
☐ 9 Year ☐ 10 Year ☐ 11 Year ☐ 12 Year  
☐ 13 Year ☐ 14 Year ☐ 15 Year ☐ 16 Year  
☐ 17 Year ☐ 18 Year ☐ 19 Year ☐ 20 Year  
☐ 21 Year **OR** ☐ Reported at time of death

1. Date of Malaria diagnosis:   
year month **OR** ☐ Unk

2. Was subject hospitalized? ☐ No → Reason why: (check **all** that apply) ☐ Yes →   
year month  
i) Admission Date:   
year month  
ii) Number of days in hospital:   
iii) Number of days off work or usual activities (including hospital stay)   
☐ a. Event did not need hospitalization  
☐ b. Visited a clinic/medical professional  
☐ c. Visited a traditional healer  
☐ d. Could not get transportation on time  
☐ e. Could not afford transportation  
☐ f. Could not afford hospital care  
☐ g. Other reasons, specify: \_\_\_\_\_

### 3. Signs/Symptoms (at time of presentation)

	No	Yes	Unk
a) Acute onset of high grade fever, with chills and rigor (fever may be intermittent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Breathlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Decreased urine output	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Convulsion / unconscious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	No	Yes	Unk
g) Acute cough/throat pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Burning during micturition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Rash on body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Heatstroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Positive serology

No	Yes	Unk
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Were any of the following medications used to treat Malaria? (Select from list below)

OR ☐ No drugs ☐ Unk

- |                                      |  |   |   |
|--------------------------------------|--|---|---|
| <input type="checkbox"/> Chloroquine | <input type="checkbox"/> Pyrimethamine | <input type="checkbox"/> Artemisinin          | <input type="checkbox"/> Piperaquine            |
| <input type="checkbox"/> Primaquine  | <input type="checkbox"/> Sulfadoxine   | <input type="checkbox"/> Atovaquona           | <input type="checkbox"/> Halofantrine           |
| <input type="checkbox"/> Quinine     | <input type="checkbox"/> Pyronaridine  | <input type="checkbox"/> Tetracycline         | <input type="checkbox"/> Mefloquine             |
| <input type="checkbox"/> Proguanil   | <input type="checkbox"/> Benflumetol   | <input type="checkbox"/> Hydroxyl chloroquine | <input type="checkbox"/> Other _____<br>Specify |

6. Has subject died? ☐ No ☐ Yes

7. Please make digital copy of available supporting documentation for the subject

☐ **No supporting documents**

- ☐ Discharge report ☐ Narrative Summary ☐ Physician /Consult notes ☐ Prescription List ☐ Diagnostic test results
- ☐ Histology/Pathology report ☐ Operative/Surgical Report ☐ Laboratory test results ☐ Electrocardiogram
- ☐ Death certificate ☐ Autopsy/Post-mortem report ☐ Sputum test results ☐ Biopsy ☐ Echo Report
- ☐ Test results ☐ CT Scan ☐ MRI ☐ Spirometry report/ Lung function report
- ☐ Other \_\_\_\_\_  
Specify

*Note: These details are for tracking purposes only. The fields do not exist in ROME PURE as they are automatically obtained electronically once entered. The field worked who completes the visit must therefore enter the information into ROME PURE.*

Person Completing \_\_\_\_\_  
Report: *Print last name/first initial*

Date: 

year				month		day	

Signature of Investigator: \_\_\_\_\_

Date: 

year				month		day	

Pneumonia Event Report Number   
22000-23990

Subject ID:   
Centre # Community # Household # Member #

Subject Initials   
F M L

Baseline ID:   
Centre # U/ R Community/Village # Household # Study code / Subject ID #

Follow up Date:   
year month day

Corresponding Follow up Visit: ☐ 1 Year ☐ 2 Year ☐ 3 Year ☐ 4 Year  
☐ 5 Year ☐ 6 Year ☐ 7 Year ☐ 8 Year  
☐ 9 Year ☐ 10 Year ☐ 11 Year ☐ 12 Year  
☐ 13 Year ☐ 14 Year ☐ 15 Year ☐ 16 Year  
☐ 17 Year ☐ 18 Year ☐ 19 Year ☐ 20 Year  
☐ 21 Year **OR** ☐ Reported at time of death

1. Date of Pneumonia diagnosis:   
year month **OR** ☐ Unk

1a. Was this related to COVID-19? ☐ No ☐ Yes

2. Was subject hospitalized? ☐ No → Reason why: (check **all that apply**) ☐ Yes →   
year month i) Admission Date:

- ☐ a. Event did not need hospitalization  
☐ b. Visited a clinic/medical professional  
☐ c. Visited a traditional healer  
☐ d. Could not get transportation on time  
☐ e. Could not afford transportation  
☐ f. Could not afford hospital care  
☐ g. Other reasons \_\_\_\_\_

ii) Number of days in hospital:

iii) Number of days off work or usual activities (**including hospital stay**)

3. Signs/Symptoms (at time of presentation) No Yes Unk

- a) Acute cough (dry or productive) with high fever ☐ ☐ ☐  
b) Shortness of breath/ fast breathing ☐ ☐ ☐  
c) Chest pain ☐ ☐ ☐  
d) Blood in sputum ☐ ☐ ☐

- e) Was wheezing present? ☐ ☐ ☐  
f) Was there swelling of legs? ☐ ☐ ☐  
g) Was the abdomen swollen? ☐ ☐ ☐

No Yes Unk

4. Chest Xray ☐ ☐ ☐

5. Radiological evidence of pneumonia ☐ ☐ ☐

6. Were any of the following medications used to treat Pneumonia? (Select from list below)

OR → ☐ No drugs ☐ Unk

- |                                       |   |   |                                      |
|---------------------------------------|---|---|--------------------------------------|
| <input type="checkbox"/> Amoxicillin  | <input type="checkbox"/> Azithromycin           | <input type="checkbox"/> Clarithromycin | <input type="checkbox"/> Doxycycline |
| <input type="checkbox"/> Levofloxacin | <input type="checkbox"/> Moxifloxacin           | <input type="checkbox"/> Ceftriaxone    | <input type="checkbox"/> Ertapenem   |
| <input type="checkbox"/> Linezolid    | <input type="checkbox"/> Other _____<br>Specify |   |                                      |

7. Has subject died?

☐ No ☐ Yes

8. Please make digital copy of available supporting documentation for the subject

☐ **No supporting documents**

- |   |   |   |  |  |
|---|---|---|--|--|
| <input type="checkbox"/> Discharge report           | <input type="checkbox"/> Narrative Summary          | <input type="checkbox"/> Physician /Consult notes | <input type="checkbox"/> Prescription List                       | <input type="checkbox"/> Diagnostic test results |
| <input type="checkbox"/> Histology/Pathology report | <input type="checkbox"/> Operative/Surgical Report  | <input type="checkbox"/> Laboratory test results  | <input type="checkbox"/> Electrocardiogram                       |  |
| <input type="checkbox"/> Death certificate          | <input type="checkbox"/> Autopsy/Post-mortem report | <input type="checkbox"/> Sputum test results      | <input type="checkbox"/> Biopsy                                  | <input type="checkbox"/> Echo Report             |
| <input type="checkbox"/> Test results               | <input type="checkbox"/> CT Scan                    | <input type="checkbox"/> MRI                      | <input type="checkbox"/> Spirometry report/ Lung function report |  |
| <input type="checkbox"/> Other _____<br>Specify     |   |   |  |  |

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Person Completing  
Report:

\_\_\_\_\_  
Print last name/first initial

Date:

year				month		day

Signature of Investigator:

\_\_\_\_\_

Date:

year				month		day

TB Event  
Report Number   
18000-19990

Subject ID:   
Centre # Community # Household # Member #

Subject  
Initials   
F M L

Baseline ID:   
Centre # U/ R Community/  
Village # Household # Study code / Subject ID #

Follow up Date:   
year month day

Corresponding  
Follow up Visit: ☐ 1 Year ☐ 2 Year ☐ 3 Year ☐ 4 Year  
☐ 5 Year ☐ 6 Year ☐ 7 Year ☐ 8 Year  
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☐ 13 Year ☐ 14 Year ☐ 15 Year ☐ 16 Year  
☐ 17 Year ☐ 18 Year ☐ 19 Year ☐ 20 Year  
☐ 21 Year **OR** ☐ Reported at time of death

1. Date of TB diagnosis:   
year month **OR** ☐ Unk

2. Was subject hospitalized? ☐ No → Reason why (check all that apply) ☐ Yes →   
year month i) Admission Date:

- ☐ a. Event did not need hospitalization  
☐ b. Visited a clinic/medical professional  
☐ c. Visited a traditional healer  
☐ d. Could not get transportation on time  
☐ e. Could not afford transportation  
☐ f. Could not afford hospital care  
☐ g. Other reasons \_\_\_\_\_  
Specify

ii) Number of days in hospital:   
iii) Number of days off work or  
usual activities (including hospital stay)

3. Signs/Symptoms (at time of presentation)	No	Yes		Unk
a) Chronic cough for at least 3 weeks	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
b) Blood in sputum	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
c) Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> If YES, indicate weight lost (in kg or lbs) <input type="checkbox"/> kg <input type="checkbox"/> lbs	<input type="checkbox"/>
d) Family history of diagnosed TB	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
e) Low grade fever	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

4. Which organ was affected? ☐ Unknown

- ☐ Brain ☐ Lung ☐ Heart ☐ Abdomen ☐ Liver  
☐ Kidney ☐ Lymph nodes ☐ Miliary ☐ Other \_\_\_\_\_  
Specify

	No	Yes	Unk
5. Positive smear (sputum or body fluid microscopy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Positive culture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Positive histopathology (biopsy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. History of TB diagnosis by physician based on evidence and started on anti-tuberculosis treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TB Event  
Report Number   
18000-19990

Subject ID:   
Centre # Community # Household # Member #

Subject  
Initials   
F M L

Baseline ID:   
Centre # U/ R Community/  
Village # Household # Study code / Subject ID #

Follow up Date:   
year month day

Corresponding  
Follow up Visit: ☐ 1 Year ☐ 2 Year ☐ 3 Year ☐ 4 Year  
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☐ 13 Year ☐ 14 Year ☐ 15 Year ☐ 16 Year  
☐ 17 Year ☐ 18 Year ☐ 19 Year ☐ 20 Year  
☐ 21 Year **OR** ☐ Reported at time of death

9. Were any of the following medications used to treat TB? (Select from list below)

**OR** ☐ No drugs ☐ Unk

☐ Category I ☐ Category II ☐ Category III ☐ Category IV ☐ Non-DOTS **OR** ☐ Other

If 'Other', provide details below (check all that apply)

☐ AKT4, 4D ☐ Kanamycin (Kancin) ☐ Levofloxacin ☐ Ethambutol ☐ Rifabutin (Ributin)  
(ethambutol + isoniazid 300 mg  
+ pyrazinamide + rifampicin 450 mg)

☐ Pyrazinamide ☐ Ethionamide ☐ Isoniazid ☐ Cycloserine ☐ Capreomycin (Kapocin)

☐ Rifampicin ☐ Streptomycin (Abistryn-S) ☐ Other \_\_\_\_\_  
Specify

10. Has subject died? ☐ No ☐ Yes

11. Please make digital copy of available supporting documentation for the subject ☐ **No supporting documents**

☐ Discharge report ☐ Narrative Summary ☐ Physician /Consult notes ☐ Prescription List ☐ Diagnostic test results

☐ Histology/Pathology report ☐ Operative/Surgical Report ☐ Laboratory test results ☐ Electrocardiogram

☐ Death certificate ☐ Autopsy/Post-mortem report ☐ Sputum test results ☐ Biopsy ☐ Echo Report

☐ Test results ☐ CT Scan ☐ MRI ☐ Spirometry report/ Lung function report

☐ Other \_\_\_\_\_  
Specify

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Person Completing  
Report: \_\_\_\_\_  
Print last name/first initial

Date:   
year month day

Signature of Investigator: \_\_\_\_\_

Date:   
year month day