EVOLUTION 1/2	**EVO1**
Study code **56DX** - [_0_|_0_|_3_] - [___|___|___]	Initials [__|__|__|__|__|__]

SYMPTOMS AND VITAL SIGNS (to be completed once daily including all events/developments in the preceding 24 hours since the last assessment)			
Study day	**2**	**3**	**4**
Date (dd/mm/yy) Time (hh:mm)	[__|__]/[__|__]/[__|__] [__|__]:[__|__]	[__|__]/[__|__]/[__|__] [__|__]:[__|__]	[__|__]/[__|__]/[__|__] [__|__]:[__|__]
Fever persists? Max temp.	O Yes O No [__|__].[__] °C	O Yes O No [__|__].[__] °C	O Yes O No [__|__].[__] °C
Max resp. rate	[__|__] / minute	[__|__] / minute	[__|__] / minute
Max pulse	[__|__|__] / minute	[__|__|__] / minute	[__|__|__] / minute
Min SBP/corresponding DBP	[__|__|__]/[__|__|__] mmHg	[__|__|__]/[__|__|__] mmHg	[__|__|__]/[__|__|__] mmHg
Feeling dizzy/faint If new, date/time of onset	O Yes O No [__|__]/[__|__]/[__|__] [__|__]:[__|__]	O Yes O No [__|__]/[__|__]/[__|__] [__|__]:[__|__]	O Yes O No [__|__]/[__|__]/[__|__] [__|__]:[__|__]
Nausea If new, date/time of onset	O Yes O No [__|__]/[__|__]/[__|__] [__|__]:[__|__]	O Yes O No [__|__]/[__|__]/[__|__] [__|__]:[__|__]	O Yes O No [__|__]/[__|__]/[__|__] [__|__]:[__|__]
Vomiting If 'yes', severity If new, date/time of onset	O Yes O No + / ++ / +++ [__|__]/[__|__]/[__|__] [__|__]:[__|__]	O Yes O No + / ++ / +++ [__|__]/[__|__]/[__|__] [__|__]:[__|__]	O Yes O No + / ++ / +++ [__|__]/[__|__]/[__|__] [__|__]:[__|__]
Diarrhoea If new, date/time of onset	O Yes O No Episodes [__|__] [__|__]/[__|__]/[__|__] [__|__]:[__|__]	O Yes O No Episodes [__|__] [__|__]/[__|__]/[__|__] [__|__]:[__|__]	O Yes O No Episodes [__|__] [__|__]/[__|__]/[__|__] [__|__]:[__|__]
Abdominal pain If 'yes', severity If new, date/time of onset	O Yes O No + / ++ / +++ [__|__]/[__|__]/[__|__] [__|__]:[__|__]	O Yes O No + / ++ / +++ [__|__]/[__|__]/[__|__] [__|__]:[__|__]	O Yes O No + / ++ / +++ [__|__]/[__|__]/[__|__] [__|__]:[__|__]
Headache - Muscle/joint pain If 'yes', severity If new, date/time of onset	O Yes O No + / ++ / +++ [__|__]/[__|__]/[__|__] [__|__]:[__|__]	O Yes O No + / ++ / +++ [__|__]/[__|__]/[__|__] [__|__]:[__|__]	O Yes O No + / ++ / +++ [__|__]/[__|__]/[__|__] [__|__]:[__|__]
Signature :	_____ **[___|___|___|___]**	_____ **[___|___|___|___]**	_____ **[___|___|___|___]**

EVOLUTION 1/2	**EVO1**
Study code **56DX** - [_0_|_0_|_3_] - [___|___|___]	Initials [__|__|__|__|__|__]

SYMPTOMS AND VITAL SIGNS (to be completed once daily including all events/developments in the preceding 24 hours since the last assessment)		
Study day	**5**	**6**
Date (dd/mm/yy) Time (hh:mm)	[__|__]/[__|__]/[__|__] [__|__]:[__|__]	[__|__]/[__|__]/[__|__] [__|__]:[__|__]
Fever persists? Max temp.	○ Yes ○ No [__|__].[__] °C	○ Yes ○ No [__|__].[__] °C
Max resp. rate	[__|__] / minute	[__|__] / minute
Max pulse	[__|__|__] / minute	[__|__|__] / minute
Min SBP/corresponding DBP	[__|__|__]/[__|__|__] mmHg	[__|__|__]/[__|__|__] mmHg
Feeling dizzy/faint If new, date/time of onset	○ Yes ○ No [__|__]/[__|__]/[__|__] [__|__]:[__|__]	○ Yes ○ No [__|__]/[__|__]/[__|__] [__|__]:[__|__]
Nausea If new, date/time of onset	○ Yes ○ No [__|__]/[__|__]/[__|__] [__|__]:[__|__]	○ Yes ○ No [__|__]/[__|__]/[__|__] [__|__]:[__|__]
Vomiting If 'yes', severity If new, date/time of onset	○ Yes ○ No + / ++ / +++ [__|__]/[__|__]/[__|__] [__|__]:[__|__]	○ Yes ○ No + / ++ / +++ [__|__]/[__|__]/[__|__] [__|__]:[__|__]
Diarrhoea If new, date/time of onset	○ Yes ○ No Episodes [__|__] [__|__]/[__|__]/[__|__] [__|__]:[__|__]	○ Yes ○ No Episodes [__|__] [__|__]/[__|__]/[__|__] [__|__]:[__|__]
Abdominal pain If 'yes', severity If new, date/time of onset	○ Yes ○ No + / ++ / +++ [__|__]/[__|__]/[__|__] [__|__]:[__|__]	○ Yes ○ No + / ++ / +++ [__|__]/[__|__]/[__|__] [__|__]:[__|__]
Headache - Muscle/joint pain If 'yes', severity If new, date/time of onset	○ Yes ○ No + / ++ / +++ [__|__]/[__|__]/[__|__] [__|__]:[__|__]	○ Yes ○ No + / ++ / +++ [__|__]/[__|__]/[__|__] [__|__]:[__|__]
Signature :	_____ **[___|___|___|___]**	_____ **[___|___|___|___]**

EVOLUTION 2/2	**EVO2**
Study code **56DX** - [_0_|_0_|_3_] - [___|___|___]	Initials [__|__|__|__|__|__]

EXAMINATION (to be completed once daily before the morning dose of the study drug)

Study day	**2**	**3**	**4**
Date (dd/mm/yy) Time (hh:mm)	[__|__]/[__|__]/[__|__] [__|__]:[__|__]	[__|__]/[__|__]/[__|__] [__|__]:[__|__]	[__|__]/[__|__]/[__|__] [__|__]:[__|__]
Respiratory distress (*)	O Yes O No	O Yes O No	O Yes O No
Clinical pleural effusion (**)	O Yes O No If yes, O Small/Medium O Large	O Yes O No If yes, O Small/Medium O Large	O Yes O No If yes, O Small/Medium O Large
Rales / crackles	O Yes O No	O Yes O No	O Yes O No
Jaundice	O Yes O No	O Yes O No	O Yes O No
Abdomen tender	O Yes O No	O Yes O No	O Yes O No
Liver palpable? [Size]	O Yes O No [__|__] cm	O Yes O No [__|__] cm	O Yes O No [__|__] cm
Spleen palpable? [Size]	O Yes O No [__|__] cm	O Yes O No [__|__] cm	O Yes O No [__|__] cm
Ascites (***)	O Yes O No If yes, O Small/Medium O Large	O Yes O No If yes, O Small/Medium O Large	O Yes O No If yes, O Small/Medium O Large
Glasgow Coma Score	[_____] ([E___][M___][V___])	[_____] ([E___][M___][V___])	[_____] ([E___][M___][V___])
Lethargy	O Yes O No	O Yes O No	O Yes O No
Restlessness	O Yes O No	O Yes O No	O Yes O No
Convulsions	O Yes O No	O Yes O No	O Yes O No
Neurological abnormality. If Yes, specify	O Yes O No [_____]	O Yes O No [_____]	O Yes O No [_____]
Bleeding	O Yes O No	O Yes O No	O Yes O No
If yes, tick all appropriate boxes	☐ Bruising/Petechiae	☐ Bruising/Petechiae	☐ Bruising/Petechiae
	☐ Gum/Nose bleeding	☐ Gum/Nose bleeding	☐ Gum/Nose bleeding
	☐ Hematemesis/Melaena/Hematuria/Vaginal bl.	☐ Hematemesis/Melaena/Hematuria/Vaginal bl.	☐ Hematemesis/Melaena/Hematuria/Vaginal bl.
	☐ Other places: [_____]	☐ Other places: [_____]	☐ Other places: [_____]
If yes, requiring an intervention?	O Yes O No [_____]	O Yes O No [_____]	O Yes O No [_____]
Signature	_____ **[___|___|___|___]**	_____ **[___|___|___|___]**	_____ **[___|___|___|___]**

(*) **Respiratory distress**: Patient has all three following signs: (1) increased respiratory rate for age; (2) sign of increased work of breathing (e.g. retractions, nasal flaring, accessory muscle use); (3) need for additional support to include oxygen supplementation or intubation

(**) **Pleural effusion**: (1) Small/Medium: lower lung lobe collapsed; (2) Large: Upper lung lobe involved

(***) **Ascites**: (1) Small/Medium: Shifting dullness (+), moderate symmetrical distension; (2) Large: Marked abdominal distension

EVOLUTION 2/2	**EVO2**
Study code **56DX** - [_0_|_0_|_3_] - [___|___|___]	Initials [__|__|__|__|__|__]

EXAMINATION (to be completed once daily before the morning dose of the study drug)		
Study day	**5**	**6**
Date (dd/mm/yy) Time (hh:mm)	[__|__]/[__|__]/[__|__] [__|__]:[__|__]	[__|__]/[__|__]/[__|__] [__|__]:[__|__]
Respiratory distress (*)	○ Yes ○ No	○ Yes ○ No
Clinical pleural effusion (**)	○ Yes ○ No If yes, ○ Small/Medium ○ Large	○ Yes ○ No If yes, ○ Small/Medium ○ Large
Rales / crackles	○ Yes ○ No	○ Yes ○ No
Jaundice	○ Yes ○ No	○ Yes ○ No
Abdomen tender	○ Yes ○ No	○ Yes ○ No
Liver palpable? [Size]	○ Yes ○ No [__|__] cm	○ Yes ○ No [__|__] cm
Spleen palpable? [Size]	○ Yes ○ No [__|__] cm	○ Yes ○ No [__|__] cm
Ascites (***)	○ Yes ○ No If yes, ○ Small/Medium ○ Large	○ Yes ○ No If yes, ○ Small/Medium ○ Large
Glasgow Coma Score	[_____] ([E___][M___][V___])	[_____] ([E___][M___][V___])
Lethargy	○ Yes ○ No	○ Yes ○ No
Restlessness	○ Yes ○ No	○ Yes ○ No
Convulsions	○ Yes ○ No	○ Yes ○ No
Neurological abnormality. If YES, specify	○ Yes ○ No [_____]	○ Yes ○ No [_____]
Bleeding	○ Yes ○ No	○ Yes ○ No
If yes, tick all appropriate boxes	☐ Bruising/Petechiae	☐ Bruising/Petechiae
	☐ Gum/Nose bleeding	☐ Gum/Nose bleeding
	☐ Hematemesis/Melaena/Hematuria/Vaginal bl.	☐ Hematemesis/Melaena/Hematuria/Vaginal bl.
	☐ Other places: [_____]	☐ Other places: [_____]
If yes, requiring an intervention?	○ Yes ○ No [_____]	○ Yes ○ No [_____]
Signature	_____ **[___|___|___|___]**	_____ **[___|___|___|___]**

(*) **Respiratory distress**: Patient has all three following signs: (1) increased respiratory rate for age; (2) sign of increased work of breathing (e.g. retractions, nasal flaring, accessory muscle use); (3) need for additional support to include oxygen supplementation or intubation

(**) **Pleural effusion**: (1) Small/Medium: lower lung lobe collapsed; (2) Large: Upper lung lobe involved

(***) **Ascites**: (1) Small/Medium: Shifting dullness (+), moderate symmetrical distension; (2) Large: Marked abdominal distension

MANAGEMENT	**MAN**
Study code **56DX** - [_0_|_0_|_3_] - [___|___|___]	Initials [__|__|__|__|__|__]

MANAGEMENT (to be completed once daily including all events/developments in the preceding 24 hours since the last assessment)			
Study day	**2**	**3**	**4**
Date (dd/mm/yy) Time (hh:mm)	[__|__]/[__|__]/[__|__] [__|__]:[__|__]	[__|__]/[__|__]/[__|__] [__|__]:[__|__]	[__|__]/[__|__]/[__|__] [__|__]:[__|__]
Use of supplemental Oxygen? **Type of resp. support** **Lowest SpO2%**	○ Yes ○ No [_____] ○ NA [_____] ○ NA	○ Yes ○ No [_____] ○ NA [_____] ○ **NA**	○ Yes ○ No [_____] ○ NA [_____] ○ NA
Parenteral fluid **If yes, give total volume** **Date and time infusion started.**	○ Yes ○ No [__|__|__|__] ml [__|__]/[__|__]/[__|__] [__|__]:[__|__]	○ Yes ○ No [__|__|__|__] ml [__|__]/[__|__]/[__|__] [__|__]:[__|__]	○ Yes ○ No [__|__|__|__] ml [__|__]/[__|__]/[__|__] [__|__]:[__|__]
If yes, reason for IV fluid	☐ Shock resuscitation ☐ Haemorrhage ☐ Anorexia ☐ Persistent vomiting ☐ Other, specify [_____]	☐ Shock resuscitation ☐ Haemorrhage ☐ Anorexia ☐ Persistent vomiting ☐ Other, specify [_____]	☐ Shock resuscitation ☐ Haemorrhage ☐ Anorexia ☐ Persistent vomiting ☐ Other, specify [_____]
If yes, type of fluid given	☐ Crystalloid, ☐ Colloid ☐ Albumin ☐ Blood/Blood products ☐ Other, specify [_____]	☐ Crystalloid, ☐ Colloid ☐ Albumin ☐ Blood/Blood products ☐ Other, specify [_____]	☐ Crystalloid, ☐ Colloid ☐ Albumin ☐ Blood/Blood products ☐ Other, specify [_____]
Any antibiotics? **Which?**	○ Yes ○ No [_____]	○ Yes ○ No [_____]	○ Yes ○ No [_____]
Other medication? * **List all relevant codes as below**	○ Yes ○ No [_____]	○ Yes ○ No [_____]	○ Yes ○ No [_____]
Signature	_____ **[___|___|___|___]**	_____ **[___|___|___|___]**	_____ **[___|___|___|___]**

* Antiypretics = **A**, Antiemetic = **B**, Corticosteroids = **C**, Diuretics = **D**, Antitussive = **E**, Mucolytic = **F**, Inotropes =**G**, Anti-histamine = **I**, Vitamin = **J**, Antacid/PPI = **K**, Other = **H** plus name

MANAGEMENT	**MAN**
Study code **56DX** - [_0_|_0_|_3_] - [___|___|___]	Initials [__|__|__|__|__|__]

MANAGEMENT (to be completed once daily including all events/developments in the preceding 24 hours since the last assessment)		
Study day	**5**	**6**
Date (dd/mm/yy) Time (hh:mm)	[__|__]/[__|__]/[__|__] [__|__]:[__|__]	[__|__]/[__|__]/[__|__] [__|__]:[__|__]
Use of supplemental Oxygen? **Type of resp. support** **Lowest SpO2%**	○ Yes ○ No [_____] ○ NA [_____] ○ NA	○ Yes ○ No [_____] ○ NA [_____] ○ NA
Parenteral fluid **If yes, give total volume** **Date and time infusion started.**	○ Yes ○ No [__|__|__|__] ml [__|__]/[__|__]/[__|__] [__|__]:[__|__]	○ Yes ○ No [__|__|__|__] ml [__|__]/[__|__]/[__|__] [__|__]:[__|__]
If yes, reason for IV fluid	☐ Shock resuscitation ☐ Haemorrhage ☐ Anorexia ☐ Persistent vomiting ☐ Other, specify [_____]	☐ Shock resuscitation ☐ Haemorrhage ☐ Anorexia ☐ Persistent vomiting ☐ Other, specify [_____]
If yes, type of fluid given	☐ Crystalloid, ☐ Colloid ☐ Albumin ☐ Blood/Blood products ☐ Other, specify [_____]	☐ Crystalloid, ☐ Colloid ☐ Albumin ☐ Blood/Blood products ☐ Other, specify [_____]
Any antibiotics? **Which?**	○ Yes ○ No [_____]	○ Yes ○ No [_____]
Other medication? * **List all relevant codes as below**	○ Yes ○ No [_____]	○ Yes ○ No [_____]
Signature	_____ **[___|___|___|___]**	_____ **[___|___|___|___]**

* Antiypretics = **A**, Antiemetic = **B**, Corticosteroids = **C**, Diuretics = **D**, Antitussive = **E**, Mucolytic = **F**, Inotropes =**G**, Anti-histamine = **I**, Vitamin = **J**, Antacid/PPI = **K**, Other = **H** plus name