**Follow-up at Day 4**

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| --- | --- |
| Was the visit performed? | o Yes o No  |
| Date of Visit  | DD-MMM-YYYY |
| If not done, please provide more information |  |
| Did the participant experience any clinical events since last visit?  | o Yes o No  |
| If yes, please indicate which events:  |
| Emergency room visits due to the clinical worsening of COVID-19 (defined as participant remaining under observation for > 6 hours)  | o Yes o No  |
| Hospitalization due to the progression of COVID-19 (defined as worsening of viral pneumonia) or complications related to COVID-19  | o Yes o No  |
| Hospitalization for any cause  | o Yes o No  |
| Adverse events (including adverse drug reactions)  | o Yes, please complete adverse event logo No  |