**ELIGIBILITY WORKSHEET**

1. Is the patient a resident of a nursing home or long-term care facility
   - Includes facilities providing personal and nursing care
   - **Y** Yes  **N** No

2. Prior to this illness was the patient known to be an inpatient in any healthcare facility within the last 30 days
   - Includes one or more nights spent at a healthcare facility where treatment was provided. Hospital transfer during this episode of CAP does not count as a prior inpatient admission
   - **Y** Yes  **N** No

3. Does the patient have signs and/or symptoms that are consistent with a lower respiratory tract infection
   - Includes acute onset dyspnea (or acute increase in dyspnea), cough, and pleuritic chest pain
   - **Y** Yes  **N** No

4. Does the patient have radiological evidence of new onset infiltrate of infective origin in patients with pre-existing radiological changes, evidence of new infiltrate (consolidation)
   - **Y** Yes  **N** No

5. Is CAP the primary reason for this ICU admission
   - Includes associated complications (e.g. septic shock, respiratory failure, acute kidney injury)
   - **Y** Yes  **N** No

   **IF NO** What was the other reason:

6. Date & time of hospital admission:
   - Date & time first admitted to hospital for this illness
   - If the exact time is unknown, estimate to the nearest 15 min or enter 1 am
   - **D D / M M M Y Y Y**  **H H : M M** 24 hour clock
   - e.g. 01/JUN/2018  e.g 8:05pm = 20:05 hours

7. Date & time of first ICU admission:
   - First admission to any ICU during this hospitalisation
   - If the exact time is unknown, estimate to the nearest 15 min or enter 1 am
   - **D D / M M M Y Y Y**  **H H : M M** 24 hour clock
   - e.g. 01/JUN/2018  e.g 8:05pm = 20:05 hours

8. Organ support now (one or more of the following):
   - Check all that apply
   - Continuous vasopressor and/or inotrope infusion
   - High-flow oxygen via nasal prongs at ≥ 30 L/min
   - Non-invasive ventilation
   - Invasive mechanical ventilation

9. Most recent arterial blood gas (ABG):
   - (If taken – not mandatory)
   - **PaO₂ on the most recent ABG**
   - **Corresponding FiO₂**
   - **Corresponding PEEP**
   - **mmHg**  **kPa**
   - **e.g. 0.21**
   - **cmH₂O**

10. Is influenza infection suspected or confirmed
    - **Y** Yes  **N** No
    - As part of the current illness

11. Is death deemed imminent and inevitable in the next 24 hours AND either the patient, substitute decision maker or attending physician is not committed to active treatment?
    - **Y** Yes  **N** No

12. Date & time first IV antibiotic administered for this illness:
    - Includes Abs administered prior to this hospital admission if known
    - **D D / M M M Y Y Y**  **H H : M M** 24 hour clock
    - e.g. 01/JUN/2018  e.g 8:05pm = 20:05 hours

13. Do you suspect methicillin-resistant Staphylococcus aureus (MRSA) infection?
    - **Y** Yes  **N** No
ELIGIBILITY WORKSHEET

14. Is standard empiric antibiotic therapy for CAP appropriate
   Yes [Y] No [N]
   Exclusions include concomitant infection, resistance patterns, immunosuppression, or if microbiological testing results are available

14.1 What was the other reason:

15. Do you expect to prescribe systemic corticosteroids for an indication that is unrelated to this episode of community-acquired pneumonia?
   Yes [Y] No [N]
   e.g. continuation of long-term chronic therapy, asthma, suspected or proven Pneumocystis jiroveci pneumonia

16. Do you intend to prescribe or continue an antiviral that is active against influenza, other than oseltamivir
   Yes [Y] No [N]
   Examples of other antivirals active against influenza are zanamivir, peramivir, and baloxavir

17. Since admission to any hospital for this illness, has the patient received two or more doses of oseltamivir (or any other neuraminidase inhibitor)
   Yes [Y] No [N]
   Other neuraminidase inhibitors may include zanamivir and peramivir

18. Is the patient pregnant and/or breastfeeding?
   Yes [Y] No [N]
   Unknown [U]
   Sites in Germany cannot check “unknown”

19. Allergies and contraindications:
   Yes [Y] No [N]
   All known allergies to antibiotics, hydrocortisone, or oseltamivir

20. Is the patient awake and competent to consent
   Yes [Y] No [N]

20.1 Determine their willingness to participate before completing eligibility CRF

21. Participation in the following domain(s) is clinically acceptable and appropriate for this patient:

21.1 Antibiotic Domain:
   Yes [Y] No [N]

21.2 Corticosteroid Domain:
   Yes [Y] No [N]

21.3 Macrolide Duration Domain:
   Yes [Y] No [N]

21.4 Antiviral Domain:
   Yes [Y] No [N]

MACROLIDE REVEAL (COMPLETED ANY TIME BETWEEN RANDOMISATION AND END OF STUDY DAY 5)

1. Is the patient’s pneumonia due to microbiologically proven or strongly suspected infection with Legionella or another atypical organism
   Yes [Y] No [N]
   Other atypical causes of pneumonia include Mycoplasma and Chlamydia

2. Has macrolide been ceased for more than 36 hours
   Yes [Y] No [N]
   Since the time of randomisation in the Antibiotic Domain

3. Has agreement to participate in the macrolide duration domain been obtained
   Yes [Y] No [N]
   Prior agreement is not required in the UK

4. In the opinion of the treating clinician, is allocation to either the standard course or extended course of macrolide therapy appropriate for this patient
   Yes [Y] No [N]
   Consider risk of ventricular rhythm disturbance and QT prolongation

REMAP-CAP Eligibility Worksheet V2.0 dated 18 February 2020
https://remapcap.spinnakersoftware.com/