Appendix 1. Summary of outcome measures and physical measures collected

Questionnaires were delivered via telephone at seven and 13 months to assess function, cognition and wellbeing:

1. The Fatigue Severity Scale includes nine statements that participants endorse or deny using a seven-point Likert scale.[1] This validated outcome measure assesses the severity and frequency of fatigue, as well as its effects on daily living. Higher scores indicate higher fatigue; scores >36 indicate severe fatigue and the need for further evaluation.[1,2]
2. The functional impairment checklist was used to measure symptoms and limitation with functional tasks.[3] Validity and reliability to measure recovery has been established in the severe acute respiratory syndrome population.[3]
3. The EuroQol 5 Dimensions 5 Levels (EQ-5D-5L) is a validated, standardised instrument for measuring health-related quality of life. EQ-5D-5L measures mobility, self-care, usual activities, pain/discomfort and anxiety/depression.[1,4] Scores range from 5 to 25, with higher scores indicating increased problems.[4] This outcome measure also asks participants to rate their general health on a scale from 0 to 100, where 0 is the worst health and 100 is the best health (EQ visual analogue scale[4]). Data for the EQ-5D-5L were collected at seven and 13 months in the present study and at three months in the umbrella study.
4. Cognition was measured at six months using the telephone version of the Montreal Cognitive Assessment (T-MoCA), which specifically measures short-term memory, visual–spatial abilities, executive function, attention/concentration, language and orientation.[5,6] This outcome measure has been validated across various populations and is the most sensitive outcome measure for detecting mild cognitive impairment.[5,6] Higher scores on the T-MoCA indicate better cognition, and a cut-off of 19 (out of 22) was used to determine whether participants have mild cognitive impairment.[5,6] This outcome measure was completed first to minimise fatigue.
5. The seven-item Generalised Anxiety Disorder-7 scale (GAD-7) and the Patient Health Questionnaire-9 depression scale (PHQ-9) were used to measure the presence and severity of anxiety and depression symptoms, respectively.[7,8] These measures are among the best validated and most commonly used depression and anxiety measures for use in general medical populations, and the GAD-7 has been used in other COVID-19 studies to measure anxiety.[1] Scores >4 on the GAD-7 or >9 on the PHQ-9 were indicative of a general anxiety disorder[1,8] or depression,[7] respectively. The five-item Primary Care Post-Traumatic Stress Disorder (PTSD) Screen was used to identify likely PTSD. Patients scoring ≥3 were deemed likely to have PTSD.[9]
6. Taste and smell were measured on a scale of 0 (no smell/taste) to 10 (normal smell/taste).[10]

Physical assessment was undertaken in person between 12 and 18 months after infection to assess the following aspects:

1. Hand grip strength, as measured using a JAMAR™ dynamometer, was compared to normative values based on age and gender.[11]
2. Forced vital capacity and forced expiratory volume in one second were measured using the NDD EasyOne® Portable Handheld Diagnostic World Spirometer. Scores were interpreted using the European Respiratory Society (ERS) lower limits of normality, based on age and height.[12]
3. Blood pressure and heart rate were measured while patients were supine and while they were standing at two, five and 10 minutes to determine the presence of postural orthostatic tachycardia syndrome (POTS). POTS was considered an increase of >29 bpm or an increase >120 bpm within the first 10 minutes of standing (in the absence of orthostatic hypotension).[13]
4. Exercise capacity was measured using the six-minute walk test standardised procedure as outlined by the American Thoracic Society.[14]

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