**Hospital Discharge Summary**

* **Hospital name**: the hospital where the patient was treated.
* **Date of admission**: date the patient entered the hospital.
* **Date of discharge**: date the patient left the hospital.
* **Main reason for hospitalisation (mark only one):** if multiple reasons apply, choose the single **best reason for the admission.** 
  + **Treatment** initiation: Patient was admitted because there is a policy to routinely hospitalize patients at the beginning of treatment, and there was no other reason to be in the hospital.
  + **Infection control:** Patient was hospitalized to prevent transmission in the family or community. For example, when there is a policy to routinely hospitalize patients while they are smear-positive, and this particular patient had no other reason to be in the hospital.
  + **Adverse event:** Patient was admitted to manage an adverse event.
  + **Co-morbidity:** Patient was admitted for reasons related to a co-morbidity, for example, HIV or hepatitis C.
  + **Severe clinical condition**: Patient needed a higher level of care due to severe illness. For example, the patient was unable to care for his/herself at home due to advanced TB.
  + **Surgical operation**: Patient was hospitalized for a surgical operation or procedure, whether related to TB or not.
  + **Patient behavior**: The clinical team decided to hospitalize the patient due to behavior reasons. For example, to reinforce adherence or to intensively educate.
  + **Social reason**: For example, a homeless patient that needs a warm and safe place to sleep.
  + **Other**: Write the reason in the blank.
* **Discharge diagnosis (final reason for hospital admission)** is the final diagnosis that is judged to be the reason for the hospital admission. The admission diagnosis is the admitting doctor's best guess at the time of admission. During the hospital admission, however, it may become clear that the patient has another diagnosis that is different from the one that the doctor thought on admission. Check the discharge note, or ask the responsible doctor.

**Adverse Events**

* **Are you reporting a new AE?** Mark YES if there is a new adverse event (AE) that needs to be captured.
  + **If YES, AE ID #:** If YES is marked, then the AE form needs to be filled out by the doctor. A new AE should also be captured on the AE Log.The AE ID# assigned to this AE on the AE Form and AE log should be recorded here.
* **If reporting a new AE, is it an SAE?** If the AE fulfils the criteria of being an SAE, then mark YES and fill out an SAE form.
  + **If YES, SAE ID#:** Write the SAE Case ID # provided by the PV unit in response to the submitted SAE form. This ID must be recorded retrospectively, after the PV Unit has responded.
* **Does the patient have an ongoing adverse event that does not have a final outcome?** Any change in an AE that was not updated in the AE Log should be updated now.
* **Has there been a change in the TB regimen or concomitant medications, including dosage adjustment, stopping a medication, or adding a new medication?** During a hospitalization, there are usually multiple changes to the patient's TB regimen or concomitant medications. Make sure that these changes are accurately reflected in the Active Medication Log.

**Hospital Course**

* **Hospital course.** Describe what happened during the hospitalization, including clinical condition, tests that were done, and outcome of treatment. For complicated hospital stays, organize this description according to the patient's main problems.
* **Other notes or comments.** Write the results of any tests or studies that were performed during the hospitalization.

**TB-related surgery**

* This section is to describe any surgical procedures related to the patient's TB that occurred during this hospitalization. If the patient underwent TB-related surgery at any point during the hospitalization, capture the relevant data here.
* Other surgeries or procedures that are not related to TB should be described in the preceding section.