**Outcome**

*Instructions: This form is filled out whenever there is an outcome: after a patient dies; when a patient is judged to be lost to follow-up; when it is decided to stop treatment because of treatment failure; or on the last day of treatment in the case of cure or completed.*

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| Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Given name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Facility patient ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  EMR ID#: \_\_ \_\_ \_\_ — \_\_ \_\_ \_\_ — \_\_ \_\_ \_\_ \_\_ \_\_ | |
| Date of the end of treatment (the last day the patient received treatment): | \_\_ \_\_ /\_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_ |
| Date of end of treatment decision (the day outcome was declared): | \_\_ \_\_ /\_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_ |

*Tick only one of the outcomes in the left column, then answer the corresponding questions in the right column.*

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| **Outcome**  **(tick one)** | **Definitions and additional questions** |
| ☐ Cured | *Treatment completed as recommended by the national policy without evidence of failure AND 3 three or more consecutive cultures taken at least 30 days apart are negative after the intensive phase.* |
| ☐ Completed | *Treatment completed as recommended by the national policy without evidence of failure BUT no record that three or more consecutive cultures taken at least 30 days apart are negative after the intensive phase.* |
| ☐ Died | Date of death: \_\_ \_\_ /\_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_  Suspected primary cause of death (check only one option):  ☐ TB is immediate cause of death  ☐ TB is contributing cause of death  ☐ Surgery-related death (type of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  ☐ Cause other than TB (suspected cause: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  ☐ Cause related to TB treatment  ☐ Unknown |
| ☐ Failed | *Treatment terminated or need for permanent regimen change of at least two anti-TB drugs.*  Reason for treatment failure (check all that apply):  ☐ Lack of conversion  ☐ Bacteriological reversion after conversion to negative  ☐ Evidence of additional acquired resistance to fluoroquinolones or second-line injectable drugs  ☐ Adverse drug reactions  ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ☐ Lost to follow-up | *Treatment was interrupted for two consecutive months or more.*  Why was the patient's treatment interrupted (check all that apply)?  ☐ Patient refused to finish treatment/Bad relation with health worker  ☐ Substance abuse  ☐ Social problem: family, financial, complex social situation  ☐ Left region, country  ☐ Adverse events  ☐ No confidence in treatment  ☐ Unknown  ☐ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ☐ Not evaluated | *No treatment outcome is assigned (this includes cases transferred out to another treatment unit and whose treatment outcome is unknown).*  Did the patient transfer out? ☐ Yes ☐ No  If YES, to where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If NO, why does the patient have this outcome?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Form filled by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_ \_\_ /\_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_ |
| Form entered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_ \_\_ /\_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_ |