**Follow-up Assessment**

|  |
| --- |
| Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Given name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Facility patient ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  EMR ID#:  \_\_ \_\_ \_\_ — \_\_ \_\_ \_\_ — \_\_ \_\_ \_\_ \_\_ \_\_ |

|  |  |
| --- | --- |
| Assessment date: \_\_ \_\_ /\_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_ (DD/MMM/YYYY) | |
| Treatment facility name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Type of assessment (check one only) | ☐ 2 week assessment  ☐ Planned monthly assessment: Month\_\_\_ \_\_  ☐ Other assessment  ☐ End of treatment assessment  ☐ 6 Month post-treatment assessment |

**CLINICAL EXAMINATION**

|  |  |
| --- | --- |
| Weight (kg): \_\_ \_\_ \_\_.\_\_ | Height (cm): \_\_ \_\_ \_\_ |
| Pulse (beats per minute): \_\_ \_\_ \_\_ | Respiratory rate (per minute): \_\_ \_\_ \_\_ |

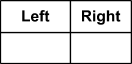
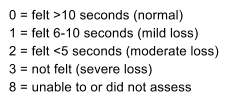
|  |  |
| --- | --- |
| Is the patient (if female) or the patient's (if male) partner currently pregnant? | ☐ Yes   ☐ No   ☐ Unknown  ☐ NA |
| If YES, write the PV Pregnancy form Case ID# | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Brief peripheral neuropathy screen**

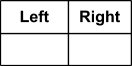
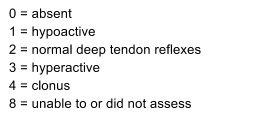
|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Normal | Mild  -------------------------------------------------------------------------------------------------------  Severe | | | | | | | | | |
| 00 | 01 | 02 | 03 | 04 | 05 | 06 | 07 | 08 | 09 | 10 |

|  |  |  |
| --- | --- | --- |
| **1. Subjective symptoms (write score for right and left legs)** | **Left** | **Right** |
| a. Pain, aching, or burning in feet, legs |  |  |
| b. "Pins and needles" in feet, legs |  |  |
| c. Numbness (lack of feeling) in feet, legs |  |  |

**2. Vibration perception (write score for right and left legs)**

**3. Ankle reflexes (write score for right and left legs)**

**Visual acuity**

|  |  |
| --- | --- |
| Left eye | 20 /\_\_ \_\_ \_\_ |
| Right eye | 20 /\_\_ \_\_ \_\_ |

**Colorblindness screen (Ishihara test)**

Write the number of correct plates from 1-11 in the book of 14 plates.

|  |  |
| --- | --- |
|  | Number |
| Left eye |  |
| Right eye |  |

**OR**

**Simplified Colorblindness screen**

|  |  |
| --- | --- |
| Ishihara screen result: | ☐ Normal       ☐ Abnormal |

**ADVERSE EVENTS ASSESSMENT AND TB REGIMEN CHANGES**

|  |  |
| --- | --- |
| Are you reporting a new AE?  If YES, write AE ID # | ☐ Yes   ☐ No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| If reporting a new AE, is it an SAE?  If YES, write SAE ID: | ☐ Yes   ☐ No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does the patient have an ongoing AE/SAE that does not have a final outcome (check AE log)? | ☐ Yes   ☐ No |
| Has there been a change in the TB regimen or concomitant medications, including dosage adjustment, stopping a medication, or adding a new medication? | ☐ Yes   ☐ No |

|  |  |
| --- | --- |
| Sputum tests ordered at this assessment: | ☐ Smear  ☐ Culture  ☐ DST  ☐ Unknown |

|  |  |
| --- | --- |
| Does the patient drink alcohol? | ☐ Yes   ☐ No   ☐ Unknown |
| If YES: How many standard alcoholic drinks does the patient drink per week? \_\_\_\_\_\_\_ | |

|  |
| --- |
| Next assessment date: \_\_ \_\_ /\_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_ (DD/MM/YYYY)  Reason for next assessment (check one):  ☐ 2 week assessment  ☐ Planned monthly assessment visit: Month \_\_\_ \_\_\_  ☐ Other assessment: Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐ End of treatment assessment  ☐ 6 Month post-treatment assessment |
| Form filled by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_ \_\_ /\_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_ |
| Form entered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Date: \_\_ \_\_ /\_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_ |