**Post-treatment Month 6 Outcome**

*Instructions: This form is filled out at the 6 month post-treatment visit once test results are available. It can be filled out earlier if a post treatment outcome occurs before this visit (as in the case of a patient who was cured but then dies 3 months after finishing treatment).*

|  |  |
| --- | --- |
| Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Given name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Facility patient ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  EMR ID#: \_\_ \_\_ \_\_ — \_\_ \_\_ \_\_ — \_\_ \_\_ \_\_ \_\_ \_\_ | |
| Date of post-treatment outcome decision: | \_\_ \_\_ /\_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_ |

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

|  |  |
| --- | --- |
| **Outcome**  **(tick one)** | **Definitions and additional questions** |
| ☐ No change in outcome post-treatment | *Patient was:*   * *cured or completed and is now culture-negative with no signs of relapse; or* * *failed treatment, and has not died or been to lost to follow-up since.* |
| ☐ Died post-treatment | *Patient died after finishing treatment.*  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 |
| ☐ Relapse or recurrence | *Patient was given a treatment outcome of "cured" or "completed" at the end of treatment, and now has TB diagnosed again by a clinician.* |
| ☐ Lost to follow-up post-treatment | *Post-treatment follow-up was not possible.*  Why was the patient lost to follow-up (check all that apply)?  ☐ Patient refused follow-up/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 post-treatment outcome is assigned (this includes cases transferred out to another treatment unit and whose post-treatment outcome is unknown).*  Did the patient transfer to another facility for post-treatment follow-up? ☐ Yes ☐ No  If YES, to where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If NO, why does the patient have this outcome?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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