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| **Quarterly Post end-of-treatment encounter assessment form** | | | | | |
| **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **End of treatment outcome\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of end of treatment:** \_\_\_/\_\_\_\_/\_\_\_\_\_ | | |
| **Registration Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **EMR ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Month post end-of-treatment** |  |  | |  |  |
| **Date of visit** *DD/MMM/YYYY* | \_\_\_/\_\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_\_/\_\_\_\_\_ | | \_\_\_/\_\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_\_/\_\_\_\_\_ |
| **Type of assessment** | ⃝Telephone call  ⃝ Telephone text message  ⃝ Email  ⃝ Physical meeting in health facility  ⃝ Physical meeting elsewhere | ⃝Telephone call  ⃝ Telephone text message  ⃝ Email  ⃝ Physical meeting in health facility  ⃝ Physical meeting elsewhere | | ⃝Telephone call  ⃝ Telephone text message  ⃝ Email  ⃝ Physical meeting in health facility  ⃝ Physical meeting elsewhere | ⃝Telephone call  ⃝ Telephone text message  ⃝ Email  ⃝ Physical meeting in health facility  ⃝ Physical meeting elsewhere |
| **Person from whom the information is provided/assessment made** | ⃝ Patient himself (see question xx)  ⃝ Patient family member  ⃝ Patient friend or acquaintance  ⃝ NTP personal  ⃝ Other health professional  ⃝ Other | ⃝ Patient himself (see question xx)  ⃝ Patient family member  ⃝ Patient friend or acquaintance  ⃝ NTP personal  ⃝ Other health professional  ⃝ Other | | ⃝ Patient himself (see question xx)  ⃝ Patient family member  ⃝ Patient friend or acquaintance  ⃝ NTP personal  ⃝ Other health professional  ⃝ Other | ⃝ Patient himself (see question xx)  ⃝ Patient family member  ⃝ Patient friend or acquaintance  ⃝ NTP personal  ⃝ Other health professional  ⃝ Other |
| **Indirect information if patient not seen in person** | ⃝ patient well  ⃝ patient has left and no contact  ⃝ patient died  ⃝ patient has symptoms  ⃝ patient has been diagnosed with TB and re-enrolled in TB treatment | ⃝ patient well  ⃝ patient has left and no contact  ⃝ patient died  ⃝ patient has symptoms  ⃝ patient has been diagnosed with TB and re-enrolled in TB treatment | | ⃝ patient well  ⃝ patient has left and no contact  ⃝ patient died  ⃝ patient has symptoms  ⃝ patient has been diagnosed with TB and re-enrolled in TB treatment | ⃝ patient well  ⃝ patient has left and no contact  ⃝ patient died  ⃝ patient has symptoms  ⃝ patient has been diagnosed with TB and re-enrolled in TB treatment |
| **Clinical questions to patient only** |  |  | |  |  |
| **Have you had cough for > 2 weeks** | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No | | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No |
| **If yes, Is your cough productive?** | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No | | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No |
| **If yes, Is there blood in your sputum?** | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No | | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No |
| **Do you have fever?** | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No | | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No |
| **If yes, fever or how long(in days)** | \_\_\_\_\_\_\_\_\_\_\_days | \_\_\_\_\_\_\_\_\_\_\_days | | \_\_\_\_\_\_\_\_\_\_\_days | \_\_\_\_\_\_\_\_\_\_\_days |
| **Do you have night sweats?** | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No | | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No |
| **Have you had unexplained weight loss?** | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No | | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No |
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| **Post treatment contact/assessment continued** | | | | | |
| **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **End of treatment outcome:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of end of treatment:** \_\_\_/\_\_\_\_/\_\_\_\_\_ | | |
| **Registration Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **EMR ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **MEDICAL VISITS AND MEDICATIONS** |  |  | |  |  | |
| **Any current medications being taken?** | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No | | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No | |
| **If yes, please list** |  |  | |  |  | |
| **Any contact with a medical practitioner since completing TB treatment?** | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No | | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No | |
| **If yes, what was the purpose of visit?** |  |  | |  |  | |
| **What was the outcome of the visit?** |  |  | |  |  | |
| **HOUSEHOLD CONTACTS** |  |  | |  |  | |
| **Any household contact being treated for TB?** | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No | | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No | |
| **Any household contact symptomatic for TB? (symptoms list as above)** | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No | | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No | |
| **ACTION AT END OF ASSESSMENT** |  |  | |  |  | |
| **Is patient a possible TB relapse** | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No | | ☐ Yes ☐Unknown  ☐No | ☐ Yes ☐Unknown  ☐No | |
| **Was a culture ordered?** | ☐ Yes - When should the patient submit the culture: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_.  ☐No | ☐ Yes - When should the patient submit the culture: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_.  ☐No | | ☐ Yes - When should the patient submit the culture: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_.  ☐No | ☐ Yes - When should the patient submit the culture: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_.  ☐No | |
| **List all diagnostic tests ordered:** |  |  | |  |  | |
| **Date of next appointment:** | ☐ None ☐ Yes Where ?  Date:\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_. | ☐ None ☐ Yes Where ?  Date:\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_. | | ☐ None ☐ Yes Where ?  Date:\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_. | ☐ None ☐ Yes Where ?  Date:\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_. | |
| **Notes:** |  |  | |  |  | |
| **If 1 year post end-of-treatment, post end-of- treatment outcome form filled in ?** | ☐ Yes  ☐No | ☐ Yes  ☐No | | ☐ Yes  ☐No | ☐ Yes  ☐No | |
| **Form filled by:** |  |  | | **Form entered by** |  | |