Baseline Assessment Form

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| registration and demographics | | | |
| Name: | | Surname: | |
| Gender: ⃝ Male ⃝ Female | | Date of birth: \_\_ \_\_ /\_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_ (e.g. DD/MMM/YYYY) | |
| National Identification #: | | EMR ID #: \_\_ \_\_ \_\_ -\_\_ \_\_ \_\_ -\_\_ \_\_ \_\_ \_\_ \_\_ | |
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| contact details | | | |
| Address: | | | |
| permanent residence district: | permanent residence country**:** | | **Telephone #** |

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| treatment registration | |
| TB Register: ⃝ Basic Management Unit TB register ⃝ Second line TB register | |
| **Date of registration in DRTB National program:** \_\_ \_\_ /\_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_ | REGISTRATION NUMBER: |
| **Registration Facility:** | **facility patient ID #:** |

Date of baseline assessment: \_\_ \_\_ /\_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_ DD/MMM/YYYY

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| social history | | |
| **Has the patient ever been in prison?** | ⃝ Yes – current ⃝ Yes – past ⃝ No ⃝ Unknown | |
| **SOCIAL HISTORY (optional)** | | |
| **Does the patient drink alcohol?** | ⃝ Yes ⃝ No ⃝ UNK | **If YES, # of standard alcoholic drinks per week: \_\_\_\_\_\_** |
| **Does the patient smoke at least 1 cigarette per day?** | | ⃝ Yes ⃝ No ⃝ UNK |
| **Has the patient used intravenous drug in the past year?** | | ⃝ Yes ⃝ No ⃝ UNK |
| **Has the patient used non-prescribed, non-injectable drugs in the past year?**  (e.g. cannabis, cocaine, prescription stimulant without a prescription, methamphetamine, inhalants, sedatives, hallucinogens, street opioids) | | ⃝ Yes ⃝ No ⃝ UNK |

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| tb history | | | | | |
| **Drugs taken for greater than one month (select all that apply) :** | | | | | |
| GROUP 1 | GROUP 2 | GROUP 3 | GROUP 4 | GROUP 5 | |
| ⃝ Isoniazid | ⃝ Amikacin | ⃝ Ciprofloxacin | ⃝ Cycloserine | ⃝ Amoxicillin/clavulanate | ⃝ Imipenem/cilastatin |
| ⃝ Rifampicin | ⃝ Capreomycin | ⃝ Gatifloxacin | ⃝ Ethionamide | ⃝ Bedaquiline | ⃝ Linezolid |
| ⃝ Rifapentine | ⃝ Kanamycin | ⃝ Levofloxacin | ⃝ PAS | ⃝ Clarithromycin | ⃝ Meropenem |
| ⃝ Ethambutol | ⃝ Streptomycin | ⃝ Moxifloxacin | ⃝ Prothionamide | ⃝ Clofazamine | ⃝ Thioacetazone |
| ⃝ Pyrazinamide |  | ⃝ Ofloxacin | ⃝ Terizidone | ⃝ Delamanid |  |
| *Other, specify:* | | | *Other, specify:* | | |
| *Other, specify:* | | | *Other, specify:* | | |
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| case definition | | | | | | | |
| **WHO registration group** | ⃝ New ⃝ Relapse ⃝ Treatment after LTFU ⃝ Treatment after failure ⃝ Other previously treated patients | | | | | | |
| **History of past drug use** | ⃝ Previously treated only with first line drugs ⃝ Previously treated with second line drugs ⃝ UNK | | | | | | |
| **Disease site** | ⃝ Pulmonary ⃝ Extra pulmonary , exact site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **Detection of *M. tuberculosis*?** | ⃝ Bacteriologically confirmed ⃝ Not confirmed, clinically diagnosed | | | | | | |
| **If *Bacteriologically confirmed*, method (s) of confirmation:** *(select all that apply)* | | ⃝ Sputum smear  ⃝ Xpert MTB/RIF | | | | ⃝ Hain test  ⃝ Culture (solid or MGIT)  ⃝ Other : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Drug resistance:** | ⃝ Profile unknown ⃝ Confirmed drug susceptible ⃝ Confirmed drug resistant TB ⃝UNK | | | | | | |
| **Drug resistance subclassification profile**  *(select only one)* | ⃝ H (S) resistance  ⃝ HE (S) resistance  ⃝ R resistance with H susceptibility | | | | ⃝ Xpert MTB/RIF resistance only  ⃝ Confirmed MDR  ⃝ Confirmed pre-XDR (FQ) | | ⃝ Confirmed pre-XDR (inj)  ⃝ Confirmed XDR  ⃝ Other |
| **MDR TB or RIF resistance diagnosis date** \_\_ \_\_ /\_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_  *(first result indicating MDR or Rifampicin resistance: could be micromolecular test or clinical diagnosis)* | | | | | | | |
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| **Consent** | | | | | | | |
| **Has the Consent Form for the all oral shorter regimen been explained and signed?** | | | | ⃝Accepted ⃝ Refused ⃝ Pending to be asked  ⃝ Other (patient died, lost to follow-up, etc) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Date consent signed** \_\_ \_\_ /\_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_ | | | | If consent withdrawn: date withdrawn \_\_ \_\_ /\_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_ | | | |
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| **Treatment Start** | | | | | | | |
| **Treatment start date: \_\_ \_\_ /\_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_ DD/MMM/YYYY** | | | | | | | |
| **Is this treatment start date estimated?** | ⃝ Yes ⃝ No ⃝ UNK | | **If yes:** ⃝ Day estimated ⃝ Month estimated ⃝ Year estimated | | | | |
| **In which facility did the patient start their treatment?**  (Note: where the patient is registered, not where the patient receives treatment) | Facility name: | | | | | | |
| Facility patient ID #: | | | | | | |
| Facility district: | | | | | | |
| Facility city: | | | | | | |
| Facility country: | | | | | | |
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| **Form completed by** | Name: | Date: \_\_ \_\_ /\_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_ |
| **Form entered in the EMR by** | Name: | Date: \_\_ \_\_ /\_\_ \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_ |