**Appendix 2. Clinical Advisory Committee Request Form**

**endTB Clinical Trial Clinical Advisory Committee Request Form – P.1**

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| --- | --- | --- | --- | --- | --- |
| **Study Suject ID** |  | | **Date of request:** | |  |
| **Subject’s Date of Birth (YYYY):** |  | | **Subject’s Sex (Tick one):** | | Male Female |
| **Request Form Filled by (Name and Role):** |  | | **Responsible Clinician for the case (Name and Role):** | |  |
| **Treatment Arm (if participant already enrolled) 1 2 3 4 5 SOC** | | | | | |
| Category | Eligibility  Clinical Management  ED approval  Permanent drug change  Build SOC | If relevant:  Weight at baseline:  Weight at current date: | | If applicable:  ConMeds treatment ongoing at current date: | |
| Background information |  | | | | |
| **Question to the CAC:** | | | | | |
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| **General Subject Information** | | | | | |
| **Week Number (or UNS) and**  **Date (DD/MMM/YYYY)** | **Clinical Data**  (Vital signs, main clinical issues) | **Treatment**  (Con meds other than anti-TB drugs, hospitalization, surgery…) | | **Non-TB Test Results**  (Tests other than smear, culture, DST. Specify dates of results) | |
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| **Attached Documents (Please tick all applicable):** | Blood test results ECG traces Chest X-ray AE/SAE form(s) Concomitant Medication Log | | | | |

**endTB Clinical Trial Clinical Advisory Committee Request Form – P.2**

**(Please complete only if you are submitting a clinical management query)**

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| **MDR-TB Treatment**  (Please specify date treatment started and daily dosage (mg), change of dosage, and cessation of drugs) | | | | | | | | | | | | | | | | | | | | | | |
| Date | H | R | | E | Z | Km | | Am | Cm | Lfx | Mfx | Pto | Eto | | Cs | PAS | Bd | Dl | Lzd | Cfz | Other | Other |
| Prior |  |  | |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |
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| **Bacteriology** (Please specify sample collection date and result) | | | | | | | | | | | | | | | | |  | | | | | |
| Date | | | Smears  (0, scanty, +, ++, or +++) | | | | Culture  (P=positive, N=negative, C=Contaminated) | | | | | | | Comments | | | Date | | Weight | | Comment | |
| Prior | | |  | | | |  | | | | | | |  | | |  | |  | |  | |
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| **Drug Susceptibility Results**  (Please specify test collection date and result: R = resistant, S = susceptible, C = contaminated, N = negative) | | | | | | | | | | | | | | | | | | | | | | |
| Date | H | R | | E | Z | S | | Km | Cm | Ofx2 | Ofx8 | Eto | PAS | | Lzd | Cfz | Bd | Dl | Others |  |  |  |
| Prior |  |  | |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |
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