AMRS TB Encounter Form v1.6.2

Visit Date: / /

Name:	**AMRS ID Number:**	**TB District Registration #:**
Clinic Location:	**Sub location/ Village:** **Phone no**(every visit)**:**	**Next of Kin:**

Initial Data: (Questions. 1-6 b only need to be filled at the patient's first visit)

Sex: ☐ M ☐ F	**Age: Yrs____Mo___**	Nearest School:	1. Marital Status: ☐S ☐M ☐D ☐W ☐Se ☐N/A

2. DOT Provided By: ☐ Health Care Worker (HCW) ☐ Community Volunteer (CV) ☐ Household Member, Friend, Relative (H) ☐ Not Done (ND)

3. Type of TB: ☐ Pulmonary (P) ☐ Extrapulmonary (EP)

4.Type of Patient: ☐ New, Smear Positive ☐ New, Smear Negative ☐ New, Extrapulmonary ☐ Smear Positive, relapse(R) ☐Smear Negative, relapse (R-) ☐ Extrapulmonary,relapse (REP) ☐ Failure (F) ☐Retreatment after Defaulting (RAD) ☐ Transfer in (TI)

5. Referred By: ☐ VCT Center (VCT) ☐ HIV Care Clinic (HCC) ☐ Home-based Care (HBC) ☐ STI Clinic (STI) ☐ Private Sector (PS) ☐ Antenatal Clinic (ANC) ☐ Self-Referral (SR) ☐ Contact Invitation (CI) ☐ Chemist/Pharmacy (CP)

6a.Start Date of Treatment: ____/_____/_____

6b.Regimen: ☐ 2RHZE/6EH ☐ 2RHZE/4RH ☐ 2RHZ/6EH ☐ 2RHZ/4RH (<15 yrs) ☐ 2SRHZE/1RHZE/5RHE ☐ 2RFBHZE /4RFBH ☐ Other: - (specify)

At ALL Visits as applicable:

7. Vital Signs: BP _____/_____ Temp: _____ HR _____ RR _____ SaO2_____

Today's Weight _____ Height _____ BMI _____

8a. Is patient pregnant? ☐ Yes ☐ No 8b. If Yes, _____weeks gestation

9. Physical Exam:

10. Current TB Medications:
☐ None ☐ Rifafour (RHZE) ☐ Rifater (RHZ) ☐ 3-FDC (RHE) ☐ Ethizide (EH) ☐ Rifinah (RH) ☐ Rifampicin(R) ☐ INH (H) ☐ Pyrazinamide(Z) ☐ Ethambutol (E) ☐ Streptomycin (S) ☐ Rifabutin (RFB) ☐Other:_____

11. During the last month has the patient missed any TB medications? ☐ Yes ☐ No ☐ Not applicable
Drugs Missed: Reason(s):

12. During the last seven days how many of his/her TB pills did the patient take? ☐ None ☐ Few ☐ Half ☐ Most ☐ All
Drug(s) missed:_____
Reason(s) for missing pills in the last 7 days:_____

13. Other Meds:

13a. If yes, specify i)_____ Start date ____/____/___ Stop date ____/____/____
ii)_____ Start date ____/____/___ Stop date ____/____/____

14. Side-effects/Toxicity:

14a. Any side-effects (SE) attributable to any drug that the patient is currently taking? ☐Yes ☐ No

14b. If Yes, drug(s) :

14c. If yes, tick all that apply: ☐ Hepatitis ☐Jaundice ☐Decreased urine output ☐Rash ☐IRIS ☐Steven-Johnson syndrome ☐ Itching ☐ Hyperuricemia ☐ Neutropenia ☐ Leucopenia ☐ Thrombocytopenia ☐ Visual Impairment ☐ Hearing Impairment ☐ Neuropathy ☐ Joint Pain ☐ Lactic Acidosis ☐ Diarrhea ☐ Persistent Vomiting ☐Taste changes ☐ Abdominal Pain ☐ Anorexia ☐ Nausea ☐ Other(specify):_____

14d. Action Taken (Tick all that apply) ☐ Dose not changed ☐ Dose reduced ☐ Drug withdrawn ☐ Patient Hospitalized ☐ Drug added to treat the SE ☐ All drugs stopped

14e. If patient has any side-effects from last visit, what is the outcome?
☐ Resolved/recovered ☐ Resolving/recovering ☐ Permanent damage ☐ Worsening ☐ Other (Specify):

15. Laboratory and Investigation Results:

Test	Date	Test Result:
CXR		Code: 0=normal 1=Pl Effusion 2=Infiltrate 3=Miliary 4= Diffuse abn/non-miliary 5=Cavity 6= Cardiomegaly 7=Other abnormality
AFB Culture	____/____/_____	☐ Pos ☐ Neg ☐ NotDone
AFB Sputum Month 0	____/____/_____	☐ 1+ ☐ 2+ ☐ 3+ ☐ Neg ☐ Not Done
AFB Sputum Month 2	____/____/_____	☐ 1+ ☐ 2+ ☐ 3+ ☐ Neg ☐ Not Done
AFB Sputum Month 3	____/____/_____	☐ 1+ ☐ 2+ ☐ 3+ ☐ Neg ☐ Not Done
AFB Sputum Month 5	____/____/_____	☐ 1+ ☐ 2+ ☐ 3+ ☐ Neg ☐ Not Done
AFB Sputum Month 8	____/____/_____	☐ 1+ ☐ 2+ ☐ 3+ ☐ Neg ☐ Not Done
HIV Test	____/____/_____	☐ Pos ☐ Neg ☐ Unknown
LFTs		
SGPT(ALT)	____/____/_____	Result:
SGOT	____/____/_____	Result:
Haemogram	____/____/_____	Result: WBC _____ Hb_____ MCV_____ Platelets_____
Creatinine	____/____/_____	Result:
Genexpert:	____/____/_____	Result:
Other Tests (Specify)		Result:

16. a) Do you have a partner/s? ☐ Yes ☐ No ☐ Not applicable
b) If yes to Qn 16a above, how many? ☐ 1 ☐ 2 ☐ 3 ☐ **Other (specify)** _____
c) Has the partner/s been tested for HIV
Partner(1) Tested for HIV? ☐ Yes ☐ No If yes, result: ☐ Pos ☐ Neg ☐ Unknown
Partner(2) Tested for HIV? ☐ Yes ☐ No If yes, result: ☐ Pos ☐ Neg ☐ Unknown
Partner(3) Tested for HIV? ☐ Yes ☐ No If yes, result: ☐ Pos ☐ Neg ☐ Unknown

TB Medication Data:

17. TB Treatment: □None □Start Induction □Change to Continuation □Continue Regimen □Stop
18. Reason for stop/change: □Completed Induction □Completed Treatment □Toxicity_____ □Other_____

19. Phase of treatment ☐ Induction (New) ☐Continuation Phase (New)
☐ Retreatment (Months= 3) ☐ Retreatment, Continuation Phase (Months 4-8)

20. Medications Filled Today:

Induction Phase:	☐ RHZE (150/75/400/275 mg)	_____ tabs/day
	☐ RHZ (150/75/400 mg)	_____ tabs/day
	☐ Streptomycin	_____ gm/day
	☐ RFB (150mg)	_____tabs in alternate days
	☐ H (300mg)	_____ tabs/day
	☐ Z (500mg)	_____ tabs/day
	☐ E (400mg)	_____ tabs/day
Continuation Phase :	☐ RH (150/75mg)	_____ tabs/day
	☐ EH (400/150 mg)	_____ tabs/day
	☐ E (400 mg)	_____ tabs/day
	☐ RHE (150/75/275 mg)	_____ tabs/day
	☐ H (300mg)	_____ tabs/day
	☐ RFB (150mg)	_____tabs in alternate days

Other TB Medications/Regimens:

Drug Key:

R= Rifampin
H= Isoniazid
Z= Pyrazinamide
E= Ethambutol
S= Streptomycin
RFB= Rifabutin

21. Referrals:

Referred To: ☐ VCT Center (VCT) ☐ HIV Care Clinic (HCC) ☐ Home-based Care (HBC) ☐ STI Clinic (STI) ☐ Private Sector (PS) ☐ Antenatal Clinic (ANC)
☐ Other Referral: _____

22. Tests Ordered:

☐ Full Haemogram ☐ Hgb ☐ CD4 Panel ☐ SGPT ☐ Liver function panel (LFTs)
☐ HIV Elisa ☐ HIV Rapid Test ☐ AAFB Sputum ☐ AAFB Culture ☐ Creatinine
☐ CXR ☐Gene Xpert: ☐ Other Tests(Spec

23. Follow-up Appointment: ☐ 2 weeks ☐ 1 month ☐ Other _____ Date of Next Appointment: ___/_____/____

24. Outcome of Treatment:

24a.Outcome:
☐ Cured, smear negative (C)
☐ Treatment completed, no smear (TC)
☐ Failure, smear positive at 3 months (F3)
☐ Failure, smear positive at 5 months (F5)
☐ Failure, smear positive at 8 months (F8)
☐ Dead (D)
☐ Out of Control, defaulted (OOC)
☐ Transferred Out (TO)
☐ AMPATH_____ ☐ Non AMPATH_____

24b. Date of Outcome: / /

Care Provider: **Provider #:**