CRF 11- ACTIVE TB INITIAL EVALUATION FORM

A1.Participant's ID number C C C - C C C C **A2. Center** _____

TB0. Research Staff completing the form _____

TO BE COMPLETED WITHIN 24 HRS OF SUSPECTED TB

ACTIVE TB INITIAL EVALUATION

TB1. Date C C C C C C C C C
D D M M M Y Y Y Y

TB2. Is the study participant suspected to have active TB? c Yes c No

CONTINUE ONLY IF STUDY SUBJECT IS SUSPECTED TO HAVE ACTIVE TB

POTENTIAL SYMPTOMS OF ACTIVE TB

Does the study participant have any of the following symptoms?

TB3. Night sweats/Fever? c No c Yes TB4. If yes, provide duration_____

TB5. Cough? c No c Yes TB6. If yes, provide duration_____

TB7. Sputum production? c No c Yes TB8. If yes, provide duration_____

TB9. Other? c No c Yes TB10. If yes, specify and provide duration_____

TB11. Physical exam c No c Yes TB12. Date exam done C C C C C C C C C
D D M M M Y Y Y Y

TB13. If yes, results were: c Normal c Abnormal

TB14. If abnormal, describe _____

DESCRIPTION

TB15. Describe the symptoms and other relevant details of the suspected active TB in as much detail as possible

_____

_____

_____

_____

TREATMENT

NOTE: Treatment should follow National TB program and/or WHO guidelines

TB16. Treatment: c treatment not started yet (investigation still ongoing) c started 2HRZE/4RH

c started other treatment TB17. If other, specify _____

TB18. Date treatment started C C C C C C C C C
D D M M M Y Y Y Y

REMINDER

- **Chest x-rays are needed at 3 time points (see below), send results for all 3 to the coordinating center**
  - **1 - Randomization**
  - **2 - Time of TB diagnosis (now)**
  - **3 - End of the TB treatment**
- **Culture at the time of the diagnosis is mandatory – at least 2 sputum samples for AFB smear and TB culture must be done**