CRF 14- DEATH DURING POST TREATMENT FOLLOW-UP FORM

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

H0.Research staff completing the form ______________________

PLEASE COMPLETE THIS FORM WITHIN 24h OF DEATH

DEATH DURING POST-TREATMENT INFORMATION

H1. Date form is completed C C C C C C C C C
D D M M M Y Y Y Y

H2. Date of death of the participant C C C C C C C C C
D D M M M Y Y Y Y

H3. Was the patient hospitalized before dying? C Yes C No

H4. Was Active TB likely the cause/contributor of death? C Yes C No

If Yes, please complete ACTIVE TB report CRF11 form.

H5. If No, which was the most probable cause of death?________________________________

NARRATIVE

H6. **Narrative that describes the circumstance of death.**
Make sure that all the points below are mentioned in the narrative (If any of the points below are not known, please specify that there were "NOT DONE" or "NOT KNOWN").

1) Hospitals where participant has been hospitalized
2) Treating physicians and dates of hospitalization
3) List of symptoms and duration
4) Laboratory done and results
5) Relevant images done and results
6) Names of disease diagnosed
7) Treatment received by participant
8) Autopsy results
9) Any other relevant information

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NOTE: Get and document permission to obtain clinical, laboratory, treatment information, and copies of relevant X-rays from participant's treating physician.