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| Site name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Site ID: |\_\_\_\_|\_\_\_\_| |
| Name of the investigator completing the form and signature:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date the form is completed: |\_\_\_\_|\_\_\_\_|/|\_\_\_\_|\_\_\_\_|/20|\_\_\_\_|\_\_\_\_| (DD/MM/20YY) |
| SCREENING FORM |

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| Participant information | |
| Date of screening | |\_\_\_\_|\_\_\_\_|/|\_\_\_\_|\_\_\_\_|/20|\_\_\_\_|\_\_\_\_| (DD/MM/20YY) |
| Clinic record number | [format to adapt to each site] |
| Sex | Female  Male |
| Date of birth | |\_\_\_\_|\_\_\_\_|/|\_\_\_\_|\_\_\_\_|/20|\_\_\_\_|\_\_\_\_| (DD/MM/20YY) |

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| Eligibility criteria | |
| A. Inclusion criteria | |
| 1. Is the child younger than 10 years old at the date of the screening? | Yes  No |
| 2. Does the child have any of the following symptoms or signs which have lasted more than 2 weeks? | |
| * Cough | Yes  No |
| * Fever | Yes  No |
| * Lethargy | Yes  No |
| * Weight loss   *More than 5% reduction in weight compared with the highest weight in the previous 3 months OR failure to thrive OR MUAC ≤125mm in children between 6 months and 5 years old* | Yes  No |
| B. Exclusion criteria | |
| 1. Has the child recently been diagnosed with TB disease? | Yes  No |
| 2. Has the parent or guardian signed the Informed Consent Form? | Yes  No |
| 3. When applicable, does the child agree to participate in the study? | Yes  No  Not Applicable |

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| Is the child presenting immediate danger signs and needs to be transferred out? |
| Yes  No |

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| Participant Identification (PID) | | |
| Was the participant already included? | | Yes  No |
| *If Yes, please keep the same PID and increment the previous Episode ID by one.*  *If No, please allocate a PID and Episode ID is 01.* | | |
| PID | [format to adapt to each site, like: | Site Nb | Clinic record number | ] | |
| Episode ID | |\_\_\_\_|\_\_\_\_| | |
| Any comment:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |