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| Site ID: |\_\_\_\_|\_\_\_\_| |
| Name of the investigator completing the form and signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date the form is completed: |\_\_\_\_|\_\_\_\_|/|\_\_\_\_|\_\_\_\_|/20|\_\_\_\_|\_\_\_\_| (DD/MM/20YY) |
| PID |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_| Episode ID |\_\_\_\_|\_\_\_\_| |
| ASSESSMENT & MANAGEMENT FORM |
| Visit information |
| Date of initial assessment  | |\_\_\_\_|\_\_\_\_|/|\_\_\_\_|\_\_\_\_|/20|\_\_\_\_|\_\_\_\_| (DD/MM/20YY) |
| Assessing healthcare worker | [ ]  Paediatrician [ ]  Other doctor [ ]  Clinical officer [ ]  Nurse |
| [ ]  Other If Other, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Risk of progression |
| 1. Is the child under 2 years old? | [ ]  Yes [ ]  No |
| 2. Does the child live with HIV? | [ ]  Yes [ ]  No [ ]  Do not know |
| 3. Does the child have severe acute malnutrition? | [ ]  Yes [ ]  No [ ]  Do not know |
| Empirical (non-TB) treatment |
| 1. Did you start to treat empirically the child? | [ ]  Yes (please answer all the questions in this section) [ ]  No (please go to the ‘Bacteriological test’ section)  |
| 1.a. Please specify which other disease(s) than TB are you suspecting? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1.b. Please give details on the treatment initiated: | - Which treatment was initiated?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_- For how many days? |\_\_\_\_|\_\_\_\_| |
| 2. Did the child come back? | [ ]  Yes (please answer 2a, 2b and 2c) [ ]  No |
| If Yes, the child came back for review, please answer the questions below: |
| a. Please give the date of the new visit (DD/MM/20YY) | |\_\_\_\_|\_\_\_\_|/|\_\_\_\_|\_\_\_\_|/20|\_\_\_\_|\_\_\_\_| |
| b. Are the symptoms persisting/getting worse? | [ ]  Yes [ ]  No |
| c. Do you consider that the clinical problem is solved? | [ ]  Yes [ ]  No |

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| Bacteriological test |
| Were specimens collected for mycobacterial testing? | [ ]  Yes, please select the testing done below [ ]  No, please go to ‘Exposure assessment’ |
| Test type (please choose all tests performed and report in the corresponding forms) | [ ]  Microscopy[ ]  Xpert MTB, MTB/RIF (ultra)[ ]  TrueNat MTB, RIF Dx[ ]  TB-LAMP[ ]  LF-LAM[ ]  Culture, liquid or solid media[ ]  Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Exposure assessment |
| Is the child a close or household TB contact? | [ ]  Yes [ ]  No [ ]  Do not know |
| X-Ray |
| Was an X-ray performed? | [ ]  Yes, please complete the corresponding form[ ]  No |
| Clinical assessment |
| Which of the following signs or symptoms are present: |
| * Cough longer than 2 weeks?
 | [ ]  Yes [ ]  No |
| * Fever longer than 2 weeks?
 | [ ]  Yes [ ]  No |
| * Lethargy?
 | [ ]  Yes [ ]  No |
| * Weight loss?
 | [ ]  Yes [ ]  No |
| * Haemoptysis?
 | [ ]  Yes [ ]  No |
| * Night sweat?
 | [ ]  Yes [ ]  No |
| * Swollen lymph nodes?
 | [ ]  Yes [ ]  No |
| * Tachycardia?
 | [ ]  Yes [ ]  No |
| * Tachypnoea?
 | [ ]  Yes [ ]  No |

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| Therapeutic-decision algorithm (TDA) score calculation |
| Was a TDA score calculated?*If Yes, please fill the corresponding form* | [ ]  Yes:  [ ]  TDA ‘A’ (with X-Ray) [ ]  TDA ‘B’ (without X-Ray)[ ]  No, please go to ‘Initial assessment outcome’ |

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| Initial assessment outcome |
| Decision date | |\_\_\_\_|\_\_\_\_|/|\_\_\_\_|\_\_\_\_|/20|\_\_\_\_|\_\_\_\_| (DD/MM/20YY) |
| Treatment decision | [ ]  TB treatment started. [ ]  TB treatment not started |
| If non-TB diagnosis confirmed, please specify the diagnosis | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |