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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 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |