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1. Patient ID number (unique) ________ 2. TB case registration # ________

2.1 Date of contact: ___ / ___ / ____ (Day / Mo / Year) 2.2 Date of record: ___ / ___ / ____ (Day / Mo / Year)

Demographic

3. Patient name

3.1 Surname 1 ____________ 3.1 Surname 2 ____________

3.2 First name ____________ 3.2 First name 2 ____________

4. Date of birth ___ / ___ / ____ (Day / Mo / Year) 4.1 Place of birth ____________ (City, Province)

5. Sex ◯ M ◯ F

6. Citizenship ◯ Peru ◯ RF ◯ Haiti ◯ Other 6.1 Race ____________

7. Address ◯ Current ◯ Previous ◯ Homeless

7.1 Region ____________ 7.2 District ____________

7.3 City/village ____________ 7.4 Street ____________

7.5 Building # ________ Apt. #________ 7.6 Postal Code ____________

7.7 Telephone #____________

8. Health Center ____________

8.1 Health Center Address ____________

9. Civil Status ◯ Married ◯ Living together ◯ Single ◯ Divorced/Separated ◯ Widowed

10. Social status ◯ Employed ◯ Retired ◯ Student ◯ Unemployed

11. Past medical history

	yes	no	unknown
a HIV/AIDS	◯	◯	◯
b Diabetes mellitus	◯	◯	◯
c Alcoholism	◯	◯	◯
d Substance abuse	◯	◯	◯
e Tobacco use	◯	◯	◯
f Gastric ulcer	◯	◯	◯
g Seizure disorder	◯	◯	◯
h Depression	◯	◯	◯
i Psychiatric disorder	◯	◯	◯
j Chronic lung disease	◯	◯	◯
k Cardiovascular disease	◯	◯	◯
l Active hepatitis/cirrhosis	◯	◯	◯
m Chronic renal insufficiency	◯	◯	◯
n Massive hemoptysis (> 250 cc)	◯	◯	◯
o Respiratory insufficiency	◯	◯	◯

12. Contact History

Name of Contact	Relationship	Date of first TB diagnosis	Age when first diagnosed	Living with patient when contact had TB	Multiple treatments?	Died During Treatment?	Current Condition*

* C=cured
T=in treatment
S=symtomatic without treatment
D=died

Comments: ____________

Patient name ________________ Patient ID ________________

13. TB Diagnosis (check all that apply)

Pulmonary

- ⬭ Primary TB
- ⬭ Focal TB
- ⬭ Infiltrative TB
- ⬭ Tuberculoma
- ⬭ Cavernosus TB
- ⬭ Fibrosus – cavernosus TB
- ⬭ Miliary TB

Extrapulmonary

- ⬭ TB of upper respiratory tract
- ⬭ Pleurisy
- ⬭ Skin
- ⬭ Peripheral lymph nodes
- ⬭ Meningitis and CNS
- ⬭ Bones and joints
- ⬭ GI
- ⬭ Eye
- ⬭ Intrathoracic lymph nodes
- ⬭ Kidneys/urinary tract
- ⬭ Genitals
- ⬭ Potts disease
- ⬭ TB intoxication/systemic symptoms

Other complications: ________________________________

14. Treatment history

14.1 Date first diagnosed with TB ___ / ___ (Mo / Year)

14.2 Number of previous treatments ________

15. Patient type (mark one)

- ⬭ New
- ⬭ Relapse
- ⬭ Treatment failure
- ⬭ Return after interruption
- ⬭ Re-treatment failure (chronic)
- ⬭ Transfer from other facility

16.1 Previous tuberculosis treatment regimes

	Date of treament initiation	Duration (months)	Initial Smear (+/-)	Treatment scheme (e.g. EZS/2HREZ/ $4H_2R_2E_2$)	Health center	# missed doses	Smear status at end of treatment? (+/-)	Culture status at end of treatment? (+/-)	Condition at end of treatment (Cure/ Failure/Abandon/ Transfer)
1									C F A T
2									C F A T
3									C F A T
4									C F A T
5									C F A T
6									C F A T
7									C F A T
8									C F A T

16.2 Summary of the previously received medicines (label each one of the drugs that the patient has received):

⬭ INH ⬭ RIF ⬭ EMB ⬭ PZA ⬭ SM ⬭ KM ⬭ AMK ⬭ CM ⬭ CPX/LFX/OFX/SPX

⬭ THA ⬭ CS ⬭ AMX-CLV ⬭ THZ ⬭ CFZ ⬭ CLR ⬭ Other: ________________

Patient name ______________________ Patient ID ______________

17. Physical Exam

Date: ___ / ___ / ____ (Day / Mo / Year) Presenting Complaint: ____

Date of most recent symptoms: ___ / ___ / ____ (Day / Mo / Year) Illness onset ⬭ Acute ⬭ Chronic

⬭ Cough ⬭ Expectoration ⬭ Loss of appetite ⬭ Fever ⬭ Night sweats ⬭ Dyspnea

⬭ Loss of weight: Previous weight _______ Date ___ / ___ (Mo / Year)

⬭ Massive hemoptysis: Date of hemoptysis ___ / ___ / ___ (Day / Mo / Year)

Other presenting complaints ____

17.1 Vital Signs

Blood pressure _______ (mm Hg) Respiratory frequency _______ (/min) Heart rate ________ (/min) Temperature ________ (˚C)

17.2 Weight _______ (kg) Height _______ (cm)

17.3

System	Normal	Abnormal	Describe Abnormalities
General health	⬭	⬭	
Skin	⬭	⬭	
Head/neck/oropharynx	⬭	⬭	
Cardiovascular	⬭	⬭	
Thorax and lungs	⬭	⬭	
Abdomen	⬭	⬭	
Genito-urinary	⬭	⬭	
Extremities	⬭	⬭	
Neurlogical	⬭	⬭	
Lymph nodes	⬭	⬭	
Endocrine	⬭	⬭	

Comments: ____

Patient name ______________ Patient ID ______________

Investigations

18. Bacteriology

Smear (Specify other tissue or body fluid)

dd/mm/yy	Lab #	Result

Site: Sputum ⬭
Other ⬭ ____________________

Culture (Specify other tissue or body fluid)

dd/mm/yy	Lab #	Result

Site: Sputum ⬭
Other ⬭ ____________________

19. Chest x-ray

date: ___ / ___ / ____
Day Mo Year

	Type of examination	Mark each affected zone
⬭ Done ⬭ Not done ⬭ Digital copy	⬭ Chest X Ray ⬭ Tomogram ⬭ CT Scan	1 Cavity 2 Fibrosis 3 Infiltrate 4 Pneumothorax 5 Pleural effusion 6 Tuberculoma 7 Disseminated

19.1 Other CXR findings ____________________

____

20. Laboratory results

date: ___ / ___ / ____
Day Mo Year

	AST	ALT	Bilirubin	Creatinine	K+	Mg+	HCT	B-HCG	HIV-ELISA	TSH	Urine Prot.
Normal values											

21. DST results

date: ___ / ___ / ____
Day Mo Year

(Enter code: 1=Sensitive 2=Intermediate 3=Resistant 4=Pending)

	Lab ID	Sample ID #	INH Low	INH High	RIF	PZA	EMB	SM Low	SM High	THA	KM	CS	CM	PAS	AMK	RFB	CPX	OFX	AMX-CLV	Other
Local Lab																				
Ref Lab																				

Form 1: DOTS-Plus Case Registration Form, page 5 of 5

Patient name ______________________ Patient ID ____________

Management

22. Initial TB medication

Date of treatment initiation: ____ / ____ / _____ (Expected duration of treatment in months MUST BE RECORDED)
Day Mo Year

Drug	Dose			Frequency	Duration
	AM	PM	Nite	Per Week (1-7)	(months)
Isoniazid					
Rifampicin					
Pyrazinamide					
Ethambutol					
Streptomycin					
Ethionamide					
Kanamycin					
Cycloserine					
Capreomycin					
PAS					
Clofazimine					

Drug	Dose			Frequency	Duration
	AM	PM	Nite	Per Week (1-7)	(months)
Amikacin					
Rifabutin					
Ciprofloxacin					
Ofloxacin					
Rifater (H+R+Z)					
Rifinah (H+R)					
Thiacetazone					
Levofloxacin					
Prothionamide					
Clarithromycin					
Other					

23. Supplementary drugs

24. Information collected by (print): ____________________

Signature ______________________ Date __________

25. Information entered by (print): ____________________

Signature ______________________ Date __________

26. Information checked by (print): ____________________

Signature ______________________ Date __________

Notes

Form 2: Checklist for Initial Evaluation and Treatment Surveillance

Patient name | Patient ID

Initial Evaluation

- Initial physician evaluation
- AFB
- Culture
- Susceptibility testing
- Chest radiograph
- Laboratory analysis (includes liver function tests, creatinine, blood urea nitrogen, complete blood count, HIV, ß-HCG for women)
- Health promoter evaluation (includes socioeconomic interview, home visit)
- Family planning
- Contact screening
- Initiation of empiric regimen
- Evaluation of susceptibility testing and adjustment to definitive regimen

Routine Surveillance

During treatment

- Monthly AFB
- Monthly culture
- Monthly weight (may be weekly for malnourished patients)
- Chest radiograph every six months
- Physician evaluation every month for six months, then every three months
- Creatine and electrolytes monthly for 3 months, then every 3 months during injectable phase; in patients who are 50+ years old and/or have co-morbid disease, every week for first month, then at least monthly
- Starting at six months: evaluation for discontinuation of parenteral
- Starting at 18 months: evaluation for completion of DOTS-Plus treatment

After treatment completion:

- AFB and culture at three and six months after treatment completion
- Clinical follow-up as needed

Forms for Patient Evaluation and Surveillance

- DOTS-Plus Case Registration Form
- DOTS-Plus Regimen Summary Sheet
- DOTS-Plus Smear and Culture Summary Sheet
- DOTS-Plus Weight Surveillance Sheet
- DOTS-Plus Susceptibility Data Summary Sheet
- DOTS-Plus Adverse Reaction Summary Sheet
- DOTS-Plus Treatment Administration Sheet
- Evaluation at Completion of DOTS-Plus Treatment

Form 3: DOTS-Plus Regimen Summary Sheet

Patient name ____________________ Patient ID ____________

Health center ____________________ Date of treatment initiation: ___ / ___ / ____
Day Mo Year

Note: Report entire regimen with all doses in mg; for regimen type: E=empiric, D=definitive, A=Adjustment

Drugs used:

	Type of regimen												Reason for change

Form 4: DOTS-Plus Smear and Culture Summary Sheet

Patient name ______________________ Patient ID ______________

Health center ______________________ Date of treatment initiation: ___ / ___ / ____
Day Mo Year

Month	Date of sample	Smear result	Culture result	Culture ID #	# days culture read
Initial					
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					

Observations:

Form 5: DOTS-Plus Weight Surveillance Sheet

Patient name ______________________ Patient ID ______________

Health center ______________________ Date of treatment initiation: ___ / ___ / ____ (Day / Mo / Year)

Month	Weight (kg)	Date of weight	Height (cm)
Initial			
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			
32			
33			
34			
35			
36			

Form 6: DOTS-Plus Susceptibility Data Summary Sheet

Patient name ______________________ Patient ID ______________

Health center ______________________ Date of treatment initiation: ____ / ____ / _____
(Day / Mo / Year)

Note: If resistant, include absolute colony count (e.g. R25)

Date of Sample	ID #	INH 0.1	INH 0.2	INH 0.4	INH 1	INH 5	RIF	PZA	EMB	SM 2.0	SM 10	KM	CM	AMK	THA	CPX	CS	RFB	CLR		

Observations:

Form 7: DOTS-Plus Adverse Reaction Summary Sheet

Patient name [ ] Patient ID [ ]

Health center ______________________ Date of treatment initiation: ____ / ____ / _____
(Day / Mo / Year)

Adverse reaction	Date of presentation	Date of resolu-tion	Description	Severity 1=asymtomatic 2=does not affect daily activities 3=limits daily activities 4=life threatening, hospitalization 99=unknown	Intervention switch date	Was change made in TB regi-men? If so, date and descrip-tion of change	Outcome 1=complete resolution 2=partial resolution 3=no change 4=worse 99=none reported

Form 8: DOTS-Plus Treatment Administration Sheet, page 1 of 4

Patient name ____________________ Patient ID __________

Health center ____________________ Date of treatment initiation: ____ / ____ / _____
(Day / Mo / Year)

Patient age ______ Date of birth ____ / ____ / ____ (Day / Mo / Year) Patient Address ____________________
____

Initial AFB: Date ________ Result ____________ Lab ID # ____________

Initial culture: Date ________ Result ____________ Lab ID # ____________

TB: ⬭ Pulmonary ⬭ Extrapulmonary (specify): ____________________

Susceptibility testing: Date ________ Resistant to: ____________ Sensitive to: ____________

Date ________Resistant to:____________ Sensitive to: ____________

Date (month/day)																									
Adverse																									
Monthly weight																									
AFB control																									
Culture control																									
LMP																									

Form 8: DOTS-Plus Treatment Administration Sheet, page 2 of 4

Patient name ______________________ Patient ID ____________

Date (month/day)																									
Adverse																									
Monthly weight																									
AFB control																									
Culture control																									
LMP																									

Date (month/day)																									
Adverse																									
Monthly weight																									
AFB control																									
Culture control																									
LMP																									

Form 8: DOTS-Plus Treatment Administration Sheet, page 3 of 4

Patient name ______________________ Patient ID ______________

Date (month/day)																									
Adverse																									
Monthly weight																									
AFB control																									
Culture control																									
LMP																									

Date (month/day)																									
Adverse																									
Monthly weight																									
AFB control																									
Culture control																									
LMP																									

Form 8: DOTS-Plus Treatment Administration Sheet, page 4 of 4

Patient name ______________________ Patient ID ____________

Date (month/day)																									
Adverse																									
Monthly weight																									
AFB control																									
Culture control																									
LMP																									

Date (month/day)																									
Adverse																									
Monthly weight																									
AFB control																									
Culture control																									
LMP																									

Patient name ____________ Patient ID ____________

Health center ____________ Date of treatment initiation: ___ / ___ / ___ (Day / Mo / Year)

Evaluating physician ____________ # months in treatment ____________

months receiving injectable ____________ If > 8 months, reason for continuation of injectable ____________

Date of previous evaluation ____________ Date of treatment completion ____________

Date of current evaluation ____________ Patient present at evaluation? ⬭ Yes ⬭ No

Date of last positive smear ____________ Date of last positive culture: ____________

Current regimen (please complete regimen surveillance sheet to date) ____________

Adverse reactions (please complete adverse reaction surveillance form to date) ____________

Hospitalizations since previous evaluation? ⬭ Yes ⬭ No

If yes, hospital ____________ Dates ____________

Indication ____________ Outcome ____________

Hospitalizations since previous evaluation? ⬭ Yes ⬭ No

If yes, hospital ____________ Dates ____________

Indication ____________ Outcome ____________

Hospitalizations since previous evaluation? ⬭ Yes ⬭ No

If yes, hospital ____________ Dates ____________

Indication ____________ Outcome ____________

Surgery since previous evaluation? ⬭ Yes ⬭ No

If yes, hospital ____________ Date ____________

Procedure ____________ Surgeon ____________

Indication ____________ Outcome ____________

Patient name ______________________ Patient ID ______________

Review of DOT

Total number of doses prescribed since previous evaluation ___________

Total number of doses missed since previous evaluation ___________

Number of doses suspended due to adverse reaction ___________

Number of doses missed/refused by patient ___________

Number of doses missed due to health worker ___________

Number and cause(s) of other missed doses: ___________________________________

How many doses per day does the patient receive in health center? ___________________________

How many doses per day does the patient receive at home? ___________

Reason for receiving at home: ____

Is the patient currently working? ⬭ Yes ⬭ No

If yes, was patient working when he/she started treatment? ⬭ Yes ⬭ No

if no date resumed work ___________________ Occupation: ___________________________

Is the patient currently studying? ⬭ Yes ⬭ No

If yes, was patient studying when he/she started treatment? ⬭ Yes ⬭ No

if no date resumed class___________________ Type of study ___________________________

Is the patient able to perform activities of daily living? ⬭ Yes ⬭ No

If yes, was patient able to when he/she started treatment? ⬭ Yes ⬭ No

if no, when activities resumed _______________

Review of systems (check the following that apply)

⬭ Cough	⬭ Sputum	⬭ Poor appetite	⬭ Weight loss
⬭ Dyspnea at rest	⬭ Dyspnea on exertion	⬭ Night sweats	⬭ Vertebral pain
⬭ Bronchospasm	⬭ Back pain	⬭ Other: ________	⬭ Other: ________
⬭ Hemoptysis	Date of most recent hemoptysis ______________		Quantity in ml ________

Physical exam:

PE: BP________ HR__________ RR__________ Weight_________

Patient name ____________ Patient ID ____________

Radiographic evaluation

Date of chest radiograph ____________ Number of affected lung zones (of 6) ________

Mark each affected lobe:

- ◯ Upper left zone
- ◯ Middle left zone
- ◯ Lower left zone
- ◯ Upper right zone
- ◯ Middle right zone
- ◯ Lower right zone

Pulmonary extent of infiltrates and cavities	Left lung	Right lung
<33%		
33-66%		
>66%		

Pulmonary extent of all radiographic characteristics	Left lung	Right lung
<33%		
33-66%		
>66%		

Note presence or absence of each radiographic characteristic:

	Present	Absent	
Cavity			# of cavities: diameter of largest cavity (cm):
Heterogeneous infiltrate			
Fibrosis			
Retraction of adjacent structures			
Miliary			
Nodes			# nodes: diameter of largest node(cm): Presence of hiliary nodes:
Masses			# masses: diameter of largest node(cm):
Pleural effusion			
Pleural plaques			
Bula or pneumatoceles			
Pneumotorax			Size of PTX (cm):
Hydrotorax			Size of HTX (cm):

Improvement from initial radiograph? ____________________________

Impression/plan: ____________________________

____

____

____

____

____

Patient name ______________________ Patient ID ______________

Review of treatment outcome

Did the patient smear convert? ◯ Yes ◯ No If yes, date of first negative smear ______________

Remained smear negative? ◯ Yes ◯ No If patient did not remain smear negative, date of first recurrent positive smear? ______________

If completed treatment smear negative, date of final smear conversion ______________

Did the patient culture convert? ◯ Yes ◯ No If yes, date of first negative culture ______________

Remained culture negative? ◯ Yes ◯ No

If patient did not remain culture negative, date of first recurrent positive culture? ______________

If completed treatment culture negative, date of final culture conversion ______________

Condition at completion (check only one):

◯ **Cured**

Subsequent death, if known? ◯ Yes ◯ No

If yes, date & cause of death ______________

Subsequent treatment, if known? ◯ Yes ◯ No If yes, date of treatment initiation ______________

If known, regimen ______________

◯ **Abandoned**

Date of abandonment ______________

Reason for abandonment ______________

Date of last smear prior to abandonment ______________

Smear status ◯ Pos ◯ Neg ◯ Unknown

Date of last culture prior to abandonment: ______________

Culture status ◯ Pos ◯ Neg ◯ Unknown

Subsequent death, if known? ◯ Yes ◯ No If yes, date & cause of death ______________

Subsequent treatment, if known? ◯ Yes ◯ No If yes, date of treatment initiation: ______________

If known, regimen ______________

(continued >)

Patient name ______ Patient ID ______

Condition at completion continued (check only one):

☐ **Deceased**

Date of death ______ Died of TB? ☐ Yes ☐ No

If no, cause of death ______ Date of last smear prior to death ______

Smear status ☐ Pos ☐ Neg ☐ Unknown

Date of last culture prior to abandonment: ______

Culture status ☐ Pos ☐ Neg ☐ Unknown

☐ **Failed**

Date failure determined ______ Was regimen reinforced? ☐ Yes ☐ No

Was treatment irregular? ☐ Yes ☐ No Was repeat DST performed? ☐ Yes ☐ No

Did the DST show amplification of resistance pattern? ☐ Yes ☐ No

Subsequent death, if known? ☐ Yes ☐ No If yes, date & cause of death ______

Subsequent treatment, if known? ☐ Yes ☐ No If yes, date of treatment initiation ______

If known, regimen ______

☐ **Not known**

Observations, including efforts made to recover patient ______

______

______

______

______

______

______

______

______

Form 9: Evaluation at Completion of DOTS-Plus Treatment, page 6 of 6

Patient name ______________________ Patient ID ______________

Follow-up Plan

Smear results at three months ____

Smear results at six months ____

Culture results at three months ____

Culture results at six months ____

Was patient evaluated by clinician after completion of treatment? ☐ Yes ☐ No

date ______________ complaint __________________ action ____________________________

date ______________ complaint __________________ action ____________________________

date ______________ complaint __________________ action ____________________________