**Screening of Health Care Workers and TB treatment supporters for TB; form 2.**

**TB suspect form**

1. Health Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_/\_\_ /20\_\_
2. Personal unique number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (copy from forms 2 and 3)
3. Where was the staff referred for testing? *[ask preference for testing location!]*
   1. Sputum smears O own facility O NCH O elsewhere; where? \_\_\_\_\_\_\_\_\_\_\_
   2. Sputum culture O own facility O NCH O elsewhere; where? \_\_\_\_\_\_\_\_\_\_\_
   3. CXR O own facility O NCH O elsewhere; where? \_\_\_\_\_\_\_\_\_\_\_

(this question is needed to collect outstanding results)

**Tell staff who is TB suspect to collect own results and bring to you (caregiver).**

1. Test results

|  |  |  |  |
| --- | --- | --- | --- |
|  | Date sputum collected | Date of result | Result |
| Smear 1 |  |  | O positive O Negative O Unknown O ND |
| Smear 2 |  |  | O positive O Negative O Unknown O ND |
| Culture 1 |  |  | O positive O Negative O contaminated  O Unknown O ND |
| Culture 2 |  |  | O positive O Negative O contaminated  O Unknown O ND |
| *GeneXpert* |  |  | O positive O Negative O Unknown O ND |
| Chest x-ray |  |  | O Normal O Cavitary O Infiltrate O military  O pleural effusion O Other, specify: \_\_\_\_\_\_\_ O ND |

*Indicate ND if not done*

1. Does the employee have active TB disease: O yes O No . If yes continue. If no STOP.

**Encourage HCW to disclose positive results to department in charge or facility in charge; but stress that project will not do this.**

1. Site of active TB disease:

O PULMONARY only O Extra-pulmonary only O Both pulmonary and extra-pulmonary

1. Does the staff have bacteriologically confirmed MDR-TB? O Yes O No O Unknown
2. When did TB treatment start? \_\_/\_\_/\_\_\_\_\_
3. Where is the HCW obtaining TB treatment: O own facility O elsewhere: \_\_\_\_\_\_\_\_\_\_ O DK
4. Was the HCW hospitalized? O yes O no O DK. If yes, how long? \_\_\_\_\_\_days O DK
5. Where was the case notified? O own facility O elsewhere: \_\_\_\_\_\_\_\_\_\_\_ O DK
6. How many days was the HCW on sick leave? \_\_\_\_\_\_\_\_ days O DK
7. Treatment outcome: assessed date: \_\_/\_\_/\_\_
   1. O cure O treatment completed
   2. O default O death O failure O transfer O other

Any remarks?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_