**Screening form 1: Screening of health care workers and treatment supporters for TB**

**[Adapted from Framework for TB IC implementation; may adapt lay-out]**

**Identification**

1. Health Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Date: \_\_/\_\_ /20\_\_
2. Screener initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Personal unique number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (copy from form 3)
4. Written informed consent: O Yes O No. if no then stop!
5. Date of birth: \_\_/\_\_ /\_\_\_\_\_
6. Gender: O Male O Female

**Exposure history in job**

1. Job title/type of employment:

O Medical Officer O Medical Licensee O Clinical Officer O Nurse/clinical officer

O environmental health technologist O pharmacy staff O laboratory staff

O Classified daily employees/driver/security guard O clerical officer/administrative staff

O treatment supporter

O Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Current work location(s) (more than 1 answer possible):

O Administrative areas with no patient contact (e.g. separate building than the one with patients)

O Administrative areas with limited patient contact

O Maternity wards O Pediatric Wards

O General outpatients Department O Emergency Departments/Rooms

(Waiting room and/or consultation room and/or most areas of health centres)

O TB Outpatient (DOT) Clinics O Dental/ENT

O Intensive Care O radiology

O Inpatient medicine wards O surgical wards

O MDR-TB Wards O ARV Clinic

O laboratory O pharmacy/dispensary

***TB contact***

1. Did you have direct contact with TB patients in the last year?

*(More than 1 answer possible)*

O yes, in own household O yes, outside household

O yes, in healthcare facility O no O do not know

***TB History***

1. Did you ever use medication to prevent you from developing TB, such as Isoniazid preventive therapy:

O Yes O No O unknown. If yes

* 1. in which year did you take IPT? \_\_\_\_\_
  2. duration of treatment: \_\_\_\_\_ weeks/months

1. Are you currently on TB treatment? O yes O no
2. Did you ever have TB disease (if current fill yes): O Yes O No O unknown

If no, skip to next section on HIV

If yes can you tell about latest or current episode:

* 1. Date of diagnosis: \_\_/\_\_/\_\_\_\_ (if unknown tick here: O)
  2. Where was your TB diagnosed?

O Government facility O NGO facility O private facility

O elsewhere, specify: \_\_\_\_\_\_

* 1. How was the TB confirmed?
  2. Smear O yes O no O unknown
  3. Culture O yes O no O unknown
  4. Chest x-ray O yes O no O unknown
  5. Other O yes O no O unknown specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  6. Where did you receive treatment for your TB?

O Government facility O NGO facility O private facility

O elsewhere, specify: \_\_\_\_\_\_\_\_\_

* 1. Where was the TB notified? O own workplace O elsewhere O unknown
  2. Was your TB cured? O yes O no O unknown
  3. Have you had TB more than once? O yes O no O unknown

**HIV test and ARV use**

1. Have you ever been tested for HIV? O Yes O No
2. Date of latest HIV test:\_\_/\_\_/20\_\_ Is this less than 1 year ago? O yes O no
3. Latest HIV test result: O positive O negative O unknown O not willing to disclose
   1. If negative, never tested or unwilling to disclose: refer for voluntary counseling and testing
   2. If HIV positive: are you currently using ART? O Yes O No O not willing to disclose

**Other risk factors**

23. Smoking history

a. current smoker: O Yes O No

b. If no, past smoker: O Yes O No

1. History of diabetes: O Yes O No O DK

**TB symptoms**

1. Do you currently have any of the following symptoms?
   1. Cough O yes O no if yes: duration \_\_\_\_\_\_\_\_\_\_ days
   2. Cough with blood O yes O no if yes: duration \_\_\_\_\_\_\_\_\_\_ days
   3. Weight loss O yes O no if yes: duration \_\_\_\_\_\_\_\_\_\_ days
   4. Night sweats O yes O no if yes: duration \_\_\_\_\_\_\_\_\_\_ days
   5. Fever O yes O no if yes: duration \_\_\_\_\_\_\_\_\_\_ days
   6. Chest pain O yes O no if yes: duration \_\_\_\_\_\_\_\_\_\_ days
   7. Shortness of breath O yes O no if yes: duration \_\_\_\_\_\_\_\_\_\_ days
   8. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ duration \_\_\_\_\_\_\_\_\_\_\_\_\_\_days

*If the HCW has a cough for 2 weeks or more, or another combination of TB symptoms, consider TB suspect. For HCW known or suspected to be HIV infected, duration of symptoms is irrelevant.*

1. Is this HCW a TB suspect: O yes O no O unknown. **If yes, fill form 2 and register form 4**.

**ACTIONS (tick circle if done):**

If TB suspect referred for sputum smears, culture and CXR evaluation to rule out TB O

For TB suspects who are HIV negative or unknown: arranged HIV counseling and testing. O

**HIV test result** date: \_\_/\_\_/\_\_ O positive O negative O unknown