

----- To be filled once -----

Health Facility: .....		Date:                      /        /20	
<i>Staff Member Details</i>			
Name: .....		Written informed consent: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of birth:        /        /19		Personal unique number (e.g. staff number):	
Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Job title:	<input type="checkbox"/> Medical Doctor	<input type="checkbox"/> Nurse	<input type="checkbox"/> Other, namely:.....
Total number of years of formal education:			
Of which total number of years of formal medical training:			
Employed in this facility since:    /        /19			
Total number of years working in <u>any</u> healthcare facility, including employment at this facility:			
Type of employment: <input type="checkbox"/> administrative <input type="checkbox"/> custodial <input type="checkbox"/> laboratory <input type="checkbox"/> patient-care			
Current work location(s):.....			
(if more than one, which is the main location: .....) )			

----- to be filled every follow-up appointment and compiled with previously filled forms -----

Date:			
Personal Unique Number:			
Name:			
Change in work location within facility:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, current location(s): .. .....
Date of employment termination at this health facility (if applicable):    /        /20			
<i>Medical History</i>			
Diabetes:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other immunosuppressive condition:	<input type="checkbox"/> Yes <input type="checkbox"/> No -> which condition: ..... .....		
History of TB prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No -> in which year:		
History of bacteriologically confirmed TB disease:	<input type="checkbox"/> Yes <input type="checkbox"/> No -> in which year:		
Direct contact with TB patients inside work-place:	<input type="checkbox"/> Yes <input type="checkbox"/> No	-> <input type="checkbox"/> daily:	
in last 6 months		-> <input type="checkbox"/> weekly	
		-> <input type="checkbox"/> monthly	
		-> <input type="checkbox"/> less than monthly	
Direct contact with TB patients outside workplace:	<input type="checkbox"/> Yes <input type="checkbox"/> No	-> <input type="checkbox"/> in own household	
in last 6 months		-> <input type="checkbox"/> outside household	
Use of N95 / FFP2 respirators:	<input type="checkbox"/> No		
	<input type="checkbox"/> Yes, during specific duties only		
	<input type="checkbox"/> Yes, always		

--- also fill out other side ---

Date of latest HIV test:				
Latest HIV test result:				
		If never tested or negative: offer voluntary counseling and testing		
		Date of HIV test:     /     /		
		HIV test result:	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive
		If positive:		
		Date of latest CD4-count:     /     /20		
		CD4 count result:     /     /20		
		Current ART use:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of TB disease evaluation:		/     /20		
Sputum smear positive:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Date of sputum collection:		/     /20		
Culture positive:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Not Done
Date of specimen collection for culture:		/     /20		
Source of culture specimen:		<input type="checkbox"/> Sputum	<input type="checkbox"/> Blood	<input type="checkbox"/> Other: specify..... .....
Date of chest radiograph:		/     /20		
Result:	<input type="checkbox"/> Normal	<input type="checkbox"/> Cavitory	<input type="checkbox"/> Infiltrate	<input type="checkbox"/> Other <input type="checkbox"/> Not done
Does the employee have active TB disease:		<input type="checkbox"/> No	<input type="checkbox"/> No	If Yes, answer questions below
Site of active TB disease (choose 1):		<input type="checkbox"/> PULMONARY only		
		<input type="checkbox"/> Extra-pulmonary only		
		<input type="checkbox"/> Both pulmonary and extra-pulmonary		
Does the employee have bacteriologically confirmed MDR-TB?:		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

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