

Health Facility: Date: / /20

Name: Written informed consent: ☐ Yes ☐ No

Date of birth: / /19 Personal unique number (e.g. staff number):

Gender: Male Female

Job title: ☐ Medical Doctor ☐ Nurse ☐ 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 any healthcare facility, including employment at this facility:

Type of employment: ☐ administrative ☐ custodial ☐ laboratory ☐ patient-care

Current work location(s):

(if more than one, which is the main location:

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			
Medical History			
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:
			-> <input type="checkbox"/> weekly:
			-> <input type="checkbox"/> monthly:
			-> <input type="checkbox"/> less than monthly:
Direct contact with TB patients outside workplace:			-> <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