



Notification ID:	Family name:	Given names:
Medical Presentation (continued)		Laboratory (continued)
<b>Pulmonary TB site:</b> <input type="checkbox"/> Pulmonary only <input type="checkbox"/> Pulmonary plus other sites <i>(specify extra pulmonary site(s) below)</i> <input type="checkbox"/> Extra pulmonary only <i>(specify extra pulmonary site(s) below)</i>		10. Skin <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 11. Pus <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 12. Not tested <input type="checkbox"/> 13. Other ( <i>specify</i> )
<b>Extra pulmonary site(s) of disease:</b> <input type="checkbox"/> Pleural <input type="checkbox"/> Lymph node <input type="checkbox"/> Bone/joint <input type="checkbox"/> Genito/urinary <input type="checkbox"/> Disseminated ( <i>2 or more non-contiguous sites or military or positive blood culture</i> ) <input type="checkbox"/> Meningeal <input type="checkbox"/> Peritoneal ( <i>including all GI sites</i> ) <input type="checkbox"/> Other ( <i>specify</i> ) <input type="text"/> <input type="checkbox"/> No extra pulmonary sites		<b>Other specimens isolated by culture:</b> 1. Bronchoscopy either washings or aspirate <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 2. Lymph node <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 3. Pleural fluid <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 4. Pleural fluid <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 5. Gastric aspirate <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 6. Bone/joint fluid <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 7. Peritoneal <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 8. CSF <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 9. Genitourinary <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 10. Skin <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 11. Pus <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 12. Other ( <i>specify</i> )
Laboratory		
<b>Sputum:</b> Sputum collected: <input type="checkbox"/> Yes ( <i>if yes, date collected</i> ) <input type="checkbox"/> No <input type="text" value="d d / m m / y y y y"/> Microscopy result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested <input type="checkbox"/> Unknown Culture result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested <input type="checkbox"/> Unknown		
<b>Other specimens detected by microscopy:</b> 1. Bronchoscopy either washings or aspirate <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 2. Lymph node <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 3. Pleural fluid <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 4. Pleural biopsy <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 5. Gastric aspirate <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 6. Bone/joint fluid <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 7. Peritoneal <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 8. CSF <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 9. Genitourinary <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested		
		<b>Histology:</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested <input type="checkbox"/> Unknown
		<b>Nucleic acid testing:</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested <input type="checkbox"/> Not interpretable <input type="checkbox"/> Unknown

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**Laboratory (continued)**

**Susceptibilities:**

1. Isoniazid  
 Susceptible     Resistant     Not tested
2. Rifampicin  
 Susceptible     Resistant     Not tested
3. Pyrazinamide  
 Susceptible     Resistant     Not tested
4. Ethambutol  
 Susceptible     Resistant     Not tested
5. Streptomycin  
 Susceptible     Resistant     Not tested
6. Fluoroquinolones (Ciprofloxacin, Ofloxacin, Moxifloxacin, Levofloxacin)  
 Susceptible     Resistant     Not tested
7. Ethionamide/Prothionamide  
 Susceptible     Resistant     Not tested

**Susceptibilities (continued):**

8. Kanamycin  
 Susceptible     Resistant     Not tested
9. Capreomycin  
 Susceptible     Resistant     Not tested
10. Rifabutin  
 Susceptible     Resistant     Not tested
11. Clofazimine  
 Susceptible     Resistant     Not tested
12. Cycloserine  
 Susceptible     Resistant     Not tested
13. PAS  
 Susceptible     Resistant     Not tested
14. Linezolid  
 Susceptible     Resistant     Not tested
15. Amikacin  
 Susceptible     Resistant     Not tested

**Treatment**

**Date Treatment commenced:** d d / m m / y y y y     Not treated

Drugs used	First course						Second course (if applicable)					
	Doses	Start date	Cease date	Daily*		Thrice weekly**	Doses	Start date	Cease date	Daily*		Thrice weekly**
				O	U					O	U	
Isoniazid (H)												
Rifampicin (R)												
Ethambutol (E)												
Pyrazinamide (Z)												

\*Daily O = Observed (supervised treatment; Daily U = Unsupervised treatment    \*\*Intermittent treatment must be supervised

**Treatment outcome:**

- |  |   |
|--|---|
| <input type="checkbox"/> Cured                 | <input type="checkbox"/> Completed treatment              |
| <input type="checkbox"/> Interrupted treatment | <input type="checkbox"/> Died of TB                       |
| <input type="checkbox"/> Died of other cause   | <input type="checkbox"/> Defaulter                        |
| <input type="checkbox"/> Treatment failure     | <input type="checkbox"/> Transferred out of the country   |
| <input type="checkbox"/> Still under treatment | <input type="checkbox"/> Not followed up, outcome unknown |

**Details of Medical Practitioner/ Specialist managing this condition**

Doctor's name:  Phone number:

Address:

Doctor's signature:  Date:

**Notifying Medical Practitioner (if different from left)**

Doctor's name:  Phone number:

Address:

Doctor's signature:  Date: