Data Collection Instrument /Checklist and questionnaire

Date of data collection [___/___/_____] (dd/mm/yyyy)

Name of the data collector _________________________________ Signature _____________

Time (Started/ Ended) [___/_____; ____/______] (hr. /min)

For supervisor only:
Any incomplete or inconsistent data available: Yes/No
If yes, type and action taken: ____
____
(Please use additional blank paper if the space is not enough)
Supervisor Name ___________________________________
Signature ________________ Date [___/____/_______] (dd/mm/yyyy)

Check list

Part 1: Socio Demographic Information		
S. No	**Questions**	**Response**
1.1	Name of the treatment initiating center	.... hospital/health center
1.2	Type of treatment initiating center	Ambulatory model of care------------------1 Hospitalized/inpatient model of care------2
1.3	Patient - TB registration number	-------------------------------------
1.4	Patient medical record number (MRN)	-------------------------------------
1.5	Patient unique number(Region/type of facility/facility code/ number)	-------/--------------/-------/DR----------------
1.6	Age	.... in complete Years
1.7	Sex	Male--1 Female---------------------------------------2
1.8	Address	Urban---1 Rural--2

1.9	Distance from treatment center	
1.10	Educational Status	
	Religion	Orthodox----------------1 Protestant----------------2 Catholic------------------3 Musilim-------------------4 Others----------------------5
1.11	Family size	Two-----------1 Three----------2 Four and above-----3
1.12	Is there TB case history in your family	On Treatment in this time-----1 Previously treated --------------2
1.13	Occupation/employment	Governmental employed-----1
		Private employed/NGO--------2
		Merchant-------------------------3
		Farmer----------------------------4
		Daily laborer and other-------------5
1.14	Income/per month	In Ethiopia birr--------------
1.15	Do you know TB is curable	Yes---------------1 No----------------2 I am not sure -----3
1.16	Is TB Drugs are safe?	Yes---------------1 No----------------2 I am not sure -----3
Part 2: clinical Conditions at initiation, during treatment and at the end of intensive of treatment		
2.1	Has the patient contact person/ treatment supporter	Yes--1 No --2

2.2	If yes to question no 2.1, who was/is contact person/treatment supporter?	HEW---1 Health care worker--------------------------2 Family member------------------------------3 Self administer-------------------------------4 Health development army member---------5 Other(specifiy)------------------------98 Missing ……………………………99
2.3	Category of –TB	Smear positive pulmonary TB-------1 Smear negative pulmonary -TB------2 Extra pulmonary -TB-----------------3
2.4	Has the patient had previous history of first line TB treatment	Yes---1 No--2 Missing---------------------------------99
2.5	If yes to 2.7, what were/was the frequency of treatment?	One times-----------------------------------1 Two times-----------------------------------2 Three times---------------------------------3 Missing -------------------------------------99
2.6	What was the patient category before treatment initiation	New(N)--1 Relapse(R)------------------------------------2 Treatment after failure of New TB regimen--3 Treatment after failure of Retreatment regimen--4 Treatment after being lost to followup-----5 Transfer in(T)--------------------------------6 Others(O)-------------------------------------7 Missing-------------------------------------99

2.7	TB diagnosed date	…../…./….. (dd/mm/yyyy)
2.8	TB treatment started date	…../…./….. (dd/mm/yyyy)
2.9	Category of treatment	**New:** 2RHZE/4RH …….1 **Previously treated:** Treatment after failure:- 2RHZES/1RHZE/5RHE*) ……2*
2.10	TB treatment regimen	………………………..(Write the name of drugs)
2.10.1	Intensive phase	Yes--1 No---2 Missing --------------------------------------99
2.10.2	Continuation phase	Yes--1 No---2 Missing --------------------------------------99
2.11	Was/is the -TB treatment regimen changed?	Yes--1 No---2 Missing--------------------------------------99
2.12	If yes to number 2.11,name of changed -TB treatment regimen(drugs)	----,--------,---------,---------,---------,---- drugs(name of drug in abbreviation)
2.13	If yes, what was/is the reason?	Due to side effect---------------------------1 Due to other disease----------------------2 Due to sotck out----------------------------98 Missing ……………………………99

2.14	Weight(kg)of the patient at respective months of treatment	-------kg at initiation of treatment(zero months) .... kg at 1st month of treatment .... kg at 2th month of treatment .... kg at 3th month of treatment .... kg at 5th month of treatment .... kg at 6th month of treatment --------kg at 8th month of treatment etc.
2.15	Was the patient tested for HIV/AIDS?	Yes……………………………………1 No---2 Missing …………………………………99
2.16	If yes to question no 2.19,what was/is the HIV/AIDS status of the patient	Reactive…………………………………1 Non-reactive……………………………..2 Indeterminate……………………………3 Unknown………………………………..4
2.17	If yes to number 2.20 above, what is/was the CD4 count (write the actual number or % for children) at :	Baseline=---------1 Six months=--------2 12 months=------------3 Missing ………………99
2.18	If reactive for question number 2.21, is/was the patient put on Cotrimozale preventive therapy (CPT)	Yes -------------1[write CPT started date (DD/MM/YY)____/_____/_______] No……………………………………..2 Missing ………………………………99
2.19	If reactive for question number 2.22, is/was the patient linked to the chronic HIV/AIDS care (pre-ART)?	Yes -------------1[write the date on which linked to chronic care (DD/MM/YY)____/_____/_______] No………………………….……...2 Missing ………………………………..99

2.20	If reactive for question number 2.23, is/was the patient initiated on ART?	Yes -------------1[write the date on which initiated on ART (DD/MM/YY)____/_____/_______] No……………………………………….2 Missing ……………………………….…99
2.21	Smear conversion follow up result (only for sputum smear positives PTB): Positive---------------------------------1 Negative--------------------------------2 Not done-------------------------------3 Unknown-------------------------------4 Missing----------------------------------5	.........at 2th month of treatment ....at 3th month of treatment .... at 5th month of treatment ....at 6th month of treatment ------- at 8th month of treatment etc.
2.22	If suspected MDR X/Pert or Culture result at result: (positive-------------------------------1 Negative-------------------------------2 Not done-------------------------------3 Unknown------------------------------4 missing---------------------------------5	------at initiation of treatment(zero months) ....at 2th month of treatment ....at 3th month of treatment ....at 5th month of treatment ....at 6th month of treatment -------- at 8th month of treatment etc.
2.26	What is patient's treatment outcome at the end of 6th month (new cases) of treatment	cured -----------------1 treatment complete ------------2 treatment failure------------------------------3 Lost to follow up------------------------------4 Transfer out------------------------------------5 Died --6 Transfer to MDR RX initiating center …7 (write date of death:DD/MM/YY=-----/-----/----)7

2.27	Treatment outcome of the at 8th months (retreatment TB cases)	Cured---1 Treatment completed-----------------------2 Failed--3 Lost to follow up----------------------------4 Died--5 Transfer out----------------------------------6 Transfer to MDR RX initiating center …7 Unkown---------------------------------------8 Other(specify):------------------------------98 Missing--------------------------------------99