HEADER FOLLOW-UP EVALUATION - COHORT B
Participant ID: SUBJID - B
Visit Date: VISDAT VISIT D M O N Y Y Y Y
VISIT Visit Type: M4-6 M12 M24 TB Activation Eval Prem D/C
Instructions: Complete this form at each protocol-scheduled visit. Every effort should be made to contact the participant (or participant's contact if the participant cannot be reached). Minimally the following information should be collected and documented in the participant's study file.
IDS
A. CLINIC IDENTIFICATION IDCHGNA Not applicable
Indicate the participant's DMC or TU if changed since the last visit: Designated Microscopy Centre (DMC): Tuberculosis Unit (TU): TUIDCHG TUIDCHG
CONTACT
B. FOLLOW-UP
1. Was contact and evaluation of participant possible? CNTC Yes No, specify reason (End of form)
2. This visit was conducted: In person
By phone CNTCHOW
By email Other, specify: CONOTHSP

PID:
Visit Date:
3. Is the participant pregnant?
Yes PREGNANT
No <i>(Go to Q4)</i>
Unknown (Go to Q4)
Not assessed (Go to Q5)
Not applicable, participant is male (Go to Q5)
Participant declines to answer (Got to Q4) GESTAGE
3a. If the participant is pregnant, indicate gestational age (best estimate): weeks
4. Since the last visit, has the participant had any of the following pregnancy outcomes?
Live birth PREGOUT
Still birth (Intrauterine fetal demise >20 weeks)
Miscarriage (≤ 20 weeks)
Early termination
No, has not been pregnant (Go to Q5)
Participant declines to answer (Go to Q5)
4a. Date of outcome: PREGOUTDAT
DLLUPB
5. Did the participant receive TB prophylaxis (e.g., INH or INH/rifampin) over the study period?
Yes INH No (Go to Q6) Unknown (Go to Q6)
5a. TB prophylaxis was taken for:
Less than 3 months INHDUR
3 months to less than 6 months
6 months or more

PID:				
Visit Date:				
STBACTIVE				
6. Has the participant had any c	of the following signs or symptoms of active TB since the previous visit?			
6a. Cough: COUGH	Yes No <i>(Go to Q6b)</i>			
6ai. Duration of cough: (If new since last visit)	Weeks Not applicable COUGHDURNA			
6aii. Coughing up blood:	Yes No COUGHBLD			
6b. Fever: FEVER	Yes Unknown			
6c. Unintended weight loss:	Yes Unknown WTLOSS FAILTHRY			
6d. Failure to thrive (child):	Yes Unknown Not applicable			
6e. Fatigue or lethargy:	Yes Unknown FATIGUE			
6f. Night sweats:	Yes Unknown NIGHTSWT			
6g. Pleuritic chest pain:	Yes No Unknown CHSTPAIN			
6h. Other, specify: SIGNSOTSP				
Note: If participant has two or per standard of care.	or more of the above, encourage them to seek medical evaluation			
PROMPT				
7. Since the last visit, were any laboratory or clinical evaluations done?				
Yes No (Go to Q9) Unknown (Go to Q9) LABSYN				
8. If yes, complete the following:				
8a. AFB smear AFBYN	Yes (Complete Mycobacteriology Form F3)			
CULTUREYN	No			
8b. TB culture	Yes (Complete Mycobacteriology Form F3)			
No				
8c. Chest X-ray CXRYN	Voc (Complete Chart V Bay Form FO)			
	Yes (Complete Chest X-Ray Form F9)			
	No			
8d. Other				
8d. Other OTHEVALYN	No OTHEVALSE			

PID:	FINAL 25 JUN 2015
Visit Date:	
9. Did the participant start a multi anti-TB drug regimen? TBTRTYN TBTRTYN (Co. Lo. 212)	
Yes No (Go to Q10) Unknown (Go to Q10)	
9a. If yes, report multi anti-TB treatment start date: D D M O N Y Y	YY
10. Has the participant been diagnosed with active TB:	
Yes (Complete Final Outcome Determination Form F98B and Off-Study Form No TBDIAG	m F99B)
Note: Answer Q11 and Q12 only if participant is attending the study visit in person	
DEMOGVS HEIGHT	(NEEHT
11. Height: (Only if ≤21 cm or Knee height (Only if unable to stand	
Years of age) Not Applicable	
12. Weight: kg Check if estimated weight (estimate only if u WEIGHT)	nable to stand)