GUM LABEL of patient *(including Name, Sex, Age or DOB, HKID/ Passport/ Birth certificate no., Clinic/ Hospital no.)*	DOS: _ _/_ _/_ _ _ _ ***(for chest clinic use only)*** AE no.: _____ Cat.: _____ Tx no.: _____ DOA: _ _/_ _/_ _ _ _

PFA - To be completed at around DOS (for TB patients) *[DOS = date of starting treatment (or, if patient defaulted>2 months before starting anti-TB treatment, put down the date of diagnosis)]*

Part (A) Information on this episode of TB:

Reason for presentation: 1. Symptom / 2.Contact Screening / 3. Pre-employment / 4.Pre-emigration/ 5.Other body check / 6. Incidental to other illness / 7. Others: _____

Contact with TB patients: N / Y: 1.Household / 2.Work / 3.Casual
1. within 2 year / 2. over 2 year

Part (B) Case category (choose 1 item only):

1. New case (< 1m previous Rx)
(<1m previous Rx)
2. Relapse case.
3. Treatment after default.
4. Failure of previous treatment.

Date of last treatment (mm/yyyy): _ _ / _ _ _ _ Duration of last treatment: _ _ months

Part (C) Disease classification: (please circle ≥1 item)

1. Pulmonary tuberculosis
Extent of disease: 1minimal (total area< RUL)/ 2moderate (> RUL)/ 3advanced (> 1 lung) Cavity: N / Y

Extra-pulmonary tuberculosis:

2. Pleura
3. Lymph node
4. Meninges
5. Miliary
6. Abdomen
7. Bone and joint (other than spine)
8. Spine
9. Genito-urinary tract
10. Naso/oro-pharynx
11. Larynx
12. Pericardium
13. Skin
14. Other site(1), specify _____
15. Other site(2), specify _____
16. Other site(3), specify _____

Part (D) Risk Factors/co-morbidities N/Y (If Y, please circle whichever applicable)

1. Diabetes mellitus
2. Lung cancer
3. Other malignancies
4. On cytotoxic drugs
5. On steroid
6. Chronic renal failure
7. **HIV: - ve / + ve / unknown/ pending**
8. Silicosis
9. Alcoholism
10. Drug abuser
11. Gastrectomy
12. General debilitation (e.g., due to old age, immobility, stroke, etc.)
13. On biologics
14. Other(1), specify_____
15. Other(2), specify_____

Part (E) Starting regimen (choose 1 item only): *[Starting regimen = the regimen that the attending physician uses at initiation of anti-TB treatment]*

1. Standard regimen, defined as HRZ ±E or S (irrespective of dosing frequency)
2. Non-standard regimen, defined as regimens other than HRZ ±E or S

Reason for using non-standard regimen: 1.Known or suspected drug resistance/ 2. Known drug intolerance/ 3. Potential drug-drug interaction/ 4.Known medical conditions affecting choice of regimen (e.g. liver disease, poor vision, etc), specify _____ / 5. Others, specify (e.g. old age): _____

Body weight ____ kg; body height / arm span ____ cm

Drug	Dosage and route	Dose interval (e.g. 3/7, 6/7)

Remark:

Completed by: _____ (name) Tel: _____ Fax: _____

Institution: 1.Chest Clinic/ 2.Chest Hospital/ 3.General Hospital/ 4.Private Practice. ; Name (and ward) of institution: _____

[After completion, this form should be sent to:
1. *<u>for chest clinics</u>: General Office, Tung Chung Chest Clinic, 1/F, Tung Chung Health Centre, Block 1, 6 Fu Tung Street, Tung Chung, Lantau Island. Fax: (852)2109 2240.*
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GUM LABEL of patient *(including Name, Sex, Age or DOB,* *HKID/ Passport/ Birth certificate no., Clinic/ Hospital no.)*	DOS: _ _/_ _/_ _ _ _ ***(for chest clinic use only)*** AE no.: _____ Cat.: _____ Tx no.: _____ DOA: _ _/_ _/_ _ _ _

PFB – To be completed at 6 month from DOS (for TB patients)

Part (H) Mode of TB diagnosis: 1a. Bacteriological (based on positive smear and/or culture) 1b Bacteriological (based on molecular test result)/ 2.Histological/ 3.Clinical-radiological/ 4.Clinical only (choose 1 item, priority from left to right)

Bacteriological examination for MTB: P (positive), N (negative) , U (not done), NTM (Non-tuberculous Mycobacteria)

	Sputum			**Other type of specimen:** 1.gastric aspirate/ 2.pleural fluid/ 3.bronchial washing/ 4.urine/ 5.biopsy or others, specify: _____
	Pre-treatment	2 months	3 months	Pre-treatment
Smear	P / N / U	P / N / U	P / N / U	P / N / U
Culture	P / N / U / NTM	P / N / U / NTM	P / N / U / NTM	P / N / U / NTM
PCR	P / N / U			P/N/U
rpoB mutation (if PCR positive)	P / N / U			P/N/U

- **If pre-treatment culture is positive for MTB, is the ST favourable? (i.e., sensitive to HRES)**: N / Y / U (ST not done)

  If unfavourable ST, please mark S (sensitive) or R (resistant) for all ST done:

Isoniazid (H)	: S / R	Pyrazinamide	: S / R	Cycloserine	: S / R
Rifampicin (R)	: S / R	Ofloxacin	: S / R	Other (1) _____	: S / R
Ethambutol (E)	: S / R	Ethionamide	: S / R	Other (2) _____	: S / R
Streptomycin (S)	: S / R	Kanamycin	: S / R		

The ST result is based on phenotypic/genotypic test.

Completed by: _____ (name) Tel: _____ Fax: _____

Institution: 1.Chest Clinic/ 2.Chest Hospital/ 3.General Hospital/ 4.Private Practice. ; Name (and ward) of institution: _____

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PFC – To be completed at 12 month from DOS (for TB patients)

Part (I) Outcome at 12 months (please √, circle and/ or fill in the spaces provided as appropriate)

(1) Cured/ treatment completed ☐ Date treatment completed (mm/yyyy): ____/_____

(a) Status at completion:

- Bacteriological conversion ☐
- Radiological improvement ☐
- Other clinical improvement ☐
- No available evidence of response ☐

(b) After treatment completed:

No relapse ☐

Loss to follow-up ☐ Last visit date (mm/yyyy): ____/_____

Died ☐ Cause: 1.TB-related/ 2.Not TB-related/ 3.Unknown Date of death (mm/yyyy): ____/_____

Relapse ☐ Date relapse (mm/yyyy): ____/_____

- 1.Bacteriological / 2.Histological / 3.Clinical-radiological (choose 1 item, priority from left to right)

(2) Treatment incomplete (including death while on treatment) ☐

- Still on treatment, reason: 1.retreatment/ 2.extrapulm./ 3.extensive/ 4.interrupted treatment/ 5.drug resistance/ 6.poor response/ 7.non-standard regimen/ 8.DM or on immunosuppressives etc./ 9.others, specify: _____
- Died ☐ Cause: 1.TB-related/ 2.Not TB-related/ 3.Unknown Date of death (mm/yyyy): ____/_____

(3) Transferred ☐ to: 1.GP/ 2..Chest Clinic/ 3.Hospital/ 4.Outside HK Details: _____

Last treatment date (mm/yyyy): ____/_____

(4) Defaulted (defaulted treatment for a continuous period > 2m) ☐

- Never found ☐ Last visit date (mm/yyyy): ____/_____
- Retreated after default ☐ Date treatment re-started (mm/yyyy): ____/_____
- Treatment stopped by doctor ☐ Last treatment date (mm/yyyy): ____/_____

(5) Failure (persistent positive bacteriology and treatment stopped) ☐

(6) Wrong/ revised diagnosis ☐ Last treatment date (mm/yyyy): ____/_____

- New diagnosis: _____

Completed by: _____ (name) Tel: _____ Fax: _____

Institution: 1.Chest Clinic/ 2.Chest Hospital/ 3.General Hospital/ 4.Private Practice. ; Name (and ward) of institution: _____

[After completion, this form should be sent to:

1. *for chest clinics: General Office, Tung Chung Chest Clinic, 1/F, Tung Chung Health Centre, Block 1, 6 Fu Tung Street, Tung Chung, Lantau Island. Fax: (852)2109 2240.*
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PFD – To be completed at 24 month from DOS (for TB patients)

Part (J) Outcome at 24 months (please √, circle and/ or fill in the spaces provided as appropriate)

(1) Cured/ treatment completed □ Date treatment completed (mm/yyyy): ____/_____

(a) Status at completion:

- Bacteriological conversion □
- Radiological improvement □
- Other clinical improvement □
- No available evidence of response □

(b) After treatment completed:

No relapse □

Loss to follow-up □ Last visit date (mm/yyyy): ____/_____

Died □ Cause: 1.TB-related/ 2.Not TB-related/ 3.Unknown Date of death (mm/yyyy): ____/_____

Relapse □ Date relapse (mm/yyyy): ____/_____

- 1.Bacteriological / 2.Histological / 3.Clinical-radiological / 4.Clinical only (choose 1 item, priority from left to right)

(2) Treatment incomplete (including death while on treatment) □

- Still on treatment, reason: 1.retreatment/ 2.extrapulm./ 3.extensive/ 4.interrupted treatment/ 5.drug resistance/ 6.poor response/ 7.non-standard regimen/ 8.DM or on immunosuppressives etc./ 9.others, specify: _____
- Died □ Cause: 1.TB-related/ 2.Not TB-related/ 3.Unknown Date of death (mm/yyyy): ____/_____

(3) Transferred □ to: 1.GP/ 2.Chest Clinic/ 3.Hospital/ 4.Outside HK Details: _____

Last treatment date (mm/yyyy): ____/_____

(4) Defaulted (defaulted treatment for a continuous period > 2m) □

- Never found □ Last visit date (mm/yyyy): ____/_____
- Retreated after default □ Date treatment re-started (mm/yyyy): ____/_____
- Treatment stopped by doctor □ Last treatment date (mm/yyyy): ____/_____

(5) Failure (persistent positive bacteriology and treatment stopped) □

(6) Wrong/ revised diagnosis □ Last treatment date (mm/yyyy): ____/_____

- New diagnosis: _____

Completed by: _____ (name) Tel: _____ Fax: _____

Institution: 1.Chest Clinic/ 2.Chest Hospital/ 3.General Hospital/ 4.Private Practice. ; Name (and ward) of institution: _____

[After completion, this form should be sent to:

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