Annexure 15 A

RNTCP Request Card for examination of biological specimen for TB

(Required for Diagnosis of TB, Drug Sensitivity Testing and follow up)

Patient Information			
Patient name		**Age (in yrs):_____**	**Gender: ☐ M ☐ F ☐TG**
Patient mobile no. or other contact no.		**Specimen Date of collection** (DD/MM/YY)_____	**☐ Sputum ☐ Other (specify)** _____
Patient address with landmark		**HIV Status: ☐ Reactive ☐ Non-Reactive ☐ Unknown**	
		Key populations:☐Contact of known TB Patient ☐ Diabetes ☐ Tobacco ☐ Prison ☐ Miner ☐ Migrant ☐ Refugee ☐ Urban slum ☐ Health-care worker ☐Other (specify) _____	

Name referring facility (PHI/DMC /DR-TB Centre /Laboratory/other): **Health Establishment ID (NIKSHAY): _ _ _ _**	**CDL NIKSHAY ID: _ _ - _ _ _ - _ - C - _ _ - _ _ _ _ _** **RNTCP TB Reg No. _____** **Or** ☐ Not Applicable
State: _____ District:_____Tuberculosis Unit (TU): _____	

Reason for Testing:

Diagnosis and follow up of TB	
Diagnosis (NIKSHAY ID_____)	Follow up (Smear and culture)
H/O anti TB Rx for >1 month: ☐ Yes ☐ No	RNTCP TB Reg No _____ NIKSHAY ID:_____
☐ Presumptive TB ☐ Private referral ☐ Presumptive NTM Predominant symptom _____ Duration _____ days	Regimen: ☐New ☐ Previously Treated Reason: ☐ End IP ☐ End CP Post treatment:☐ 6m ☐ 12m ☐ 18m ☐ 24m

Diagnosis and follow up Drug-resistant TB		
Drug Susceptibility Testing (DST)		Follow up (Culture)
☐ Presumptive MDR TB	☐ New ☐ Previously treated ☐ At diagnosis ☐ Contact of MDR/RR TB ☐ Follow up Sm+ve ☐ Private referral ☐ Discordance resolution	PMDT TB No _____ DR TB NIKSHAY ID: _____ Regimen: ☐Regimenfor INH mono/poly resistant TB ☐Regimenfor MDR/RR TB ☐ Modified Regimenfor MDR/RR-TB + FQ/SLI resistance ☐Regimenfor XDR TB ☐ Modified Regimenfor mixed pattern resistance ☐Regimenwith Bedaquiline for MDR-TB Regimen + FQ/SLI resistance ☐Regimenwith Bedaquiline for XDR-TB ☐Regimen with Bedaquiline for failures of regimen for MDR-TB ☐Regimen with Bedaquiline for failures of regimen for XDR-TB ☐Other Treatment ☐month☐ Week :_____
☐ Presumptive H mono/poly		
☐Presumptive XDR TB	☐ MDR/RR TB at Diagnosis ☐ ≥ 4 months culture positive ☐ 3 monthly for persistent culture positives (treatment month _____) ☐ Culture reversion ☐ Failure of MDR/RR-TB regimen ☐ Recurrent case of second line treatment ☐ Discordance resolution	

Test requested:

☐ Microscopy ☐ TST ☐ IGRA ☐ Chest X-ray ☐ Cytopathology ☐ Histopathology ☐CBNAAT ☐ Culture ☐ DST
☐ Line Probe Assay ☐ Gene Sequencing ☐ Other (Please Specify) _____

Requestor Name, Designation and Signature: _____
Contact Number:_____ Email ID:_____

Results: **CDL NIKSHAY ID**Generated: _ _ - _ _ _ - _ - C - _ _ - _ _ _ _ _

Microscopy(☐ZN☐Florescent)							
	Lab Sr. No	Visual appearance	Result				
			Negative	Scanty	1+	2+	3+
Sample A							
Sample B							

Date tested: _____ **Date Reported:**_____ **Reported by:**_____
(Name and Signature)

Cartridge Based Nucleic Acid Amplification Test (CBNAAT)

Sample	☐ A ☐ B
M. Tuberculosis	☐ Detected ☐ Not Detected☐ N/A
Rif Resistance	☐ Detected ☐ Not Detected☐ Indeterminate ☐ N/A
Test	☐ Error (Please arrange for fresh sample)

Date tested: _____ **Date Reported:**_____ **Reported by:**_____
(Name and Signature)

Culture (☐ LJ☐ LC)

Lab Sr. No	Results			
	Negative	Positive	NTM (write species)	Contamination

Date Result: _____ **Date Reported:**_____ **Reported by:**_____
(Name and Signature)

Line Probe Assay (LPA)

☐ Direct ☐ Indirect Lab serial _____

First line LPA

RpoB: — locus control: present absent

WT1: present absent **WT2:** present absent **WT3:** present absent **WT4:** present absent

WT5: present absent **WT6:** present absent **WT7 :** present absent **WT8 :** present absent

MUT1 (D516V): present absent **MUT2A (H526Y):** present absent **MUT2B (H526D):** present absent **MUT3 (S531L):** present absent

KatG: — locus control: present absent

WT1 (315): present absent

MUT1 (S315T1): present absent
MUT2 (S315T2): present absent

InhA:— locus control: present absent

WT1 (-15, -16): present absent **WT2 (-8):** present absent

MUT1 (C15T): present absent **MUT2 (A16G):** present absent
MUT3A (T8C): present absent **MUT3B (T8A):** present absent

Second line LPA

gyrA:-—

locus control: present absent

WT1 (85-90): present absent
WT2 (89-93): present absent
WT3 (92-97): present absent

MUT1 (A90V): present absent
MUT2 (S91P): present absent
MUT3A (D94A): present absent
MUT3B (D94N/Y): present absent
MUT3C (D94G): present absent
MUT3D (D94H): present absent

gyrB:—-

locus control: present absent

WT1 (536-541): present absent

MUT1 (N538D): present absent
MUT2 (E540V): present absent

rrs:—-

locus control: present absent

WT1 (1401-02): present absent
WT2 (1484): present absent

MUT1 (A1401G): present absent
MUT2 (G1484T): present absent

eis:—-

locus control: present absent

WT1 (37): present absent
WT2 (14, 12, 10): present absent
WT3 (2): present absent

MUT1 (C-14T): present absent

Final LPA Interpretation: —

MTB result MTB positive MTB Negative
RIF Sensitive Resistant Indeterminate**INH** Sensitive Resistant Indeterminate
Quinolone Sensitive Resistant Indeterminate**SLID** Sensitive Resistant Indeterminate

Date Result: _____ **Date Reported:**_____ **Reported by:**_____
(Name and Signature)

Drug Susceptibility Test (DST) results

Lab Sr. No	1st line drugs						SLI			FQ			Other										
	S	H1	H2	R	E	Z	Km	Cm	Am	Lfx	Mfx (0.5)	Mfx (2)	PAS	Lzd	Cfz	Eto	Cla	Azi					

Date Result: _____ **Date Reported:**_____ **Reported by:**_____
(Name and Signature)

R: Resistant; S: Susceptible; C: Contaminated; – Not done

Other tests for TB diagnosis

Test(Please Specify): _____
Result:_____

Date reported:_____ **Reported by:**_____
(Name and Signature)

REFERRAL SLIP SR NO xxxxx

(Referring health facility copy)

Date: .....Lab referred to : .....
Name of referring HF: .....
Name of Patient: .....
Age: ..... yrs Sex: M / F
Address of patient (with landmarks)

.....

.....

.....
Patient's / Contact person's Mobile number :

_ _ _ _ _ _ _ _ _ _
Kindly tick

- ☐ Cough.....days
- ☐ Fever.....days
- ☐ Loss of weight .....days
- ☐ Night sweat.....days
- ☐ Blood in sputum/ cough.....days

☐ Contact of TB / MDR TB

Stamp of HF Referred by (Name & Sign)

REFERRAL SLIP SR NO xxxxx

(Patient copy)

Date: .....Lab referred to : .....
Name of referring HF: .....
Name of Patient: .....
Age: ..... yrs Sex: M / F
Address of patient (with landmarks)

.....

.....

.....
Patient's/ Contact person's Mobile number :

_ _ _ _ _ _ _ _ _ _
Kindly tick

- ☐ Cough.....days
- ☐ Fever.....days
- ☐ Loss of weight .....days
- ☐ Night sweat.....days
- ☐ Blood in sputum/ cough.....days

☐ Contact of TB / MDR TB

Stamp of HF Referred by (Name & Sign)

REFERRAL SLIP SR NO xxxxx

(Lab Copy)

Date: .....Lab referred to : .....
Name of referring HF: .....
Name of Patient: .....
Age: ..... yrs Sex: M / F
Address of patient (with landmarks)

.....

.....

.....
Patient's/ Contact person's Mobile number :

_ _ _ _ _ _ _ _ _ _
Kindly tick

- ☐ Cough.....days
- ☐ Fever.....days
- ☐ Loss of weight .....days
- ☐ Night sweat.....days
- ☐ Blood in sputum/ cough.....days

☐ Contact of TB / MDR TB

Stamp of HF Referred by (Name & Sign)

Annexure 15 C

REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME
Treatment Card

TB Notification No / NIKSHAY ID _____

State_____ City / District _____ TB Unit _____ PHI _____

Name _____Sex ☐ M ☐ F☐TGAge:____ Occupation_____ Socioeconomic status: APL/ BPL

Complete Address: House No. _____ Road: _____Ward/Village: _____ Town/City: _____ Taluka/Mandal:_____ District:_____

State: _____ Pin code _____ Important landmark:_____ Mobile:- _____Aadhar No. _____Area :Slum/Tribal/Migrant/Refugee

Name andAddress of contact person _____Mobile No. _____

Name of Treatment Supporter _____Designation _____Mobile No.: _____

Initial home visit by _____ Date _____Type of Treatment Adherence – DOT / Family DOT / ICT supported, specify _____ / Other ___

Date of onset of first symptom: Number of health care providers visited before diagnosis for current episode:

Disease Classification

☐ Pulmonary
☐ Extra Pulmonary
Site _____

Type of Patient

☐ New ☐Recurrent
☐ Transfer in ☐ Treatment AfterFailure
☐Treatment ☐ Others, previously treated
After LFU (Specify)_____

Basis of Diagnosis

☐Microbiologically confirmed
☐Clinical TB

Investigations (ZN / FM / CBNAAT / Liquid C / Solid C)	Lab	Lab. No.	Test result	Sample sent to CDST (date)	DST result
Pre-treatment					
End of Intensive Phase					
End of treatment					

H/O of Previous ATT:___ months of treatment___ months since end of last episode
Source of treatment:-❑ Public ❑ Private Previous regimen: _____

Other investigations (if any) with result

HIV related information

HIV Status: ❑Unknown❑Reactive❑NR Date_____ PID_____

CPT delivered on: (1) (2) (3) (4) (5) (6)

Initiated on ART: ☐ No ☐ Yes Date & ART No._____

Diabetes related information

Diabetes Status: ❑Unknown❑Diabetic❑Non-Diabetic

RBS_____ FBS_____

Initiated on ADT: ☐ No ☐ Yes Date & ADT No._____

Other co-morbidity

Details_____

Signature of MO with date _____

	<6yrs	>6yrs
No of household contacts		
No screened		
No with symptoms		
No evaluated		
No diagnosed		
No put on treatment		

No of children less than 6 years given chemoprophylaxis = _____

Name	Wt (Kg)	Dose (mg)	1	2	3	4	5	6

Addiction related information

Current Tobaccouser❑ Yes ❑ No
If yes,❑Smoking❑Smokeless Linked for cessation ❑ Yes ❑ No
If tobacco user, status of tobacco use at end of treatment ❑Quit❑ Not quit

H/o Alcohol intake❑ Yes ❑ No
If yes, linked for deaddiction❑ Yes ❑ No

Date of initiation of intensive phase _____ **Date of initiation of continuation phase** _____

Dosage frequency ❑ Daily ❑ Intermittent Drug formulations ❑ FDC ❑Combipack❑ Loose drugs Drug packaging ❑ PWB ❑ Strips

Weight Band: Adult: ☐ 25-39 Kg ☐ 40-54 Kg ☐ 55-69 Kg ☐≥70 Kg Pediatric: ☐4-7 Kg ☐8-11 Kg ☐12-15 Kg ☐16-24 Kg ☐ 25-39 Kg ☐30-39 Kg

Dosages: FDC / Combipack _____ per day Height_____ (cm)

Loose drugs		H	R	Z	E	S
	Dose					
	Pills					

Mark✓when doses are taken under direct observation, ⊘ when the dose was not observed, O when missed the dose
Record CP from fresh line

Month/ year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Wt

Retrieval Actions for Missed Doses

Date	By Whom	Whom contacted	Reason for missed doses	Outcome of retrieval action

Details of Adverse events

Date of adverse event	Details of symptoms	Action taken	Duration of management for adverse event	Outcome of adverse event

Post treatment follow up clinical & sputum

Follow up	Clinical	Sputum	CXR	Impression
6 mths of Rx				
12 mths of Rx				
18 mths of Rx				
24 mths of Rx				

Findings _____

Remarks

_____
_____
_____
_____
_____

Nutrition support (if any, give details) _____

Treatment outcome with date: _____ **signature of the MO with date:** _____

TB identity card

Name: _____

Sex ☐ M ☐ F ☐ TGAge:____

Address:_____

_____

_____

Contact No: _____

PHI _____ TU _____ District _____

NIKSHAY ID:_____

Name and designation of treatment supporter:

_____

Contact number and address of treatment supporter:

_____

☐ CPT ☐ ART ☐ Diabetic ☐ Smoker

Date of starting treatment: (DD/MM/YYYY)

Weight Band:

Adult: ☐ 25-39 Kg ☐ 40-54 Kg ☐ 55-69 Kg ☐ ≥70 Kg

Pediatric: ☐4-7 Kg ☐8-11 Kg ☐12-15 Kg ☐16-24 Kg ☐ 25-39 Kg ☐30-39 Kg

Site of Disease

☐Pulmonary
☐Extra pulmonary

Type of Patient

☐New
☐Recurrent
☐Treatment after Lost to Follow up
☐Treatment after Failure
☐Previously treated other
☐Transfer in

Treatment regimen:☐New
☐Previously treated

_____

Smear follow-up results			
End IP		End Rx	
Post Rx Month __		Post Rx Month __	
Post Rx Month __		Post Rx Month __	

Treatment outcome: _____

Date:_____

Appointment dates

_____
_____
_____
_____
_____
_____
_____
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_____
_____
_____
_____
_____

In case of side effects or queries please contact

Name and contact number:

_____
_____

RNTCP PMDT Treatment Card

NIKSHAY ID	CDL NIKSHAY ID	PMDT NIKSHAY ID	PMDT TB No

Patient's name: _____

Age: _____yrsGender: ☐ Male ☐ Female ☐ Transgender

Address: _____

_____

Marital status: _____

Occupation: _____

Contact No: _____

Name, designation of treatment supporter:_____

_____

Contact no:_____

State:_____District: _____

TB Unit: _____ PHI:_____

Initial home v: Date _____By:_____

DR TB Centre:_____

Reason for Testing	
☐ New ☐ Previously Treated	
☐ Presumptive TB ☐ Private Referral ☐ Presumptive NTM	
☐ Presumptive MDR TB	☐ At diagnosis ☐Contact of MDR/RR TB ☐ Follow up Sm+ve at end IP ☐ Private referral
☐ Presumptive H mono/poly	
☐ Presumptive XDR TB	☐ MDR/RR TB at diagnosis ☐ ≥ 4 months culture positive ☐ 3 monthly, for persistent culture positives (treatment month _____) ☐ Culture reversion ☐ Failure of MDR/RR-TB regimen ☐ Recurrent case of second line treatment

☐ Transfer in from Other DR TB Centre

Name of DR TB Centre _____

PMDT NIKSHAY ID_____

HIV Testing: Date:_____ Result:_____ PID no._____

Date of starting CPT: _____ Date of starting ART:_____

Contact tracing:

No of household contacts				
No of members screened				
No of presumptive TB cases identified				
No of presumptive TB cases evaluated				
No diagnosed with TB				
No of DR-TB diagnosed				

TB Site:☐ Pulmonary ☐ Extra Pulmonary If extra pulmonary, please specify _____

Treatment regimen

☐Regimen for INH mono/poly resistant TB☐Regimen for MDR/RR TB ☐ Modified Regimen for MDR/RR-TB + FQ/SLI resistance ☐Regimen for XDR TB ☐ Modified Regimen for mixed pattern resistance ☐Regimen with Bedaquiline for MDR-TB Regimen + FQ/SLI resistance☐Regimen with Bedaquiline for XDR-TB☐Regimen with Bedaquiline for failures of regimen for MDR-TB☐Regimen with Bedaquiline for failures of regimen for XDR-TB☐Regimen for mixed pattern resistance

Initiation Date: _____

Registration Date: _____

Drugs and Dosages																				
Drugs	H	R	E	Z	mK	mA	mC	xf L	xf M	s C	α E	$ AP	z L d	zf C	x mA vl c	rl C	QDB			
Dose (mg)																				

Patient eligible and consented for BDQ ☐ Yes ☐ No
If No, reason_____

Name & Signature of Treating Physician:_____

DR-TB Centre Committee meetings – dates and decisions

Date	Decision	Duration of indoor stay

Month of Treatment	Culture Results			Other Investigations					
	Date	Lab No	Culture	S. Cr	LFT	ECG*-QTC Interval	CBC/ Platelets	Electrolyte(K, Mg, Ca)	Urine Gravindex
Diagnosis									
1st week									
2nd week									
3rd week									
4th week									
1									
2									
3									
4									
5									
6									
7									
8									
9									
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30									
31									
32									
33									
34									
35									

Patient's Name:_____

Blood Sugar Testing:

Date:_____

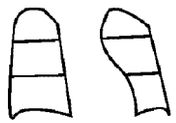
RBS:_____

FBS:_____

ADT*

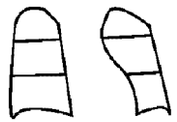
(*write date of starting)

Thyroid Function Test		
Month	Zero	Six
Date		
T3		
T4		
TSH		



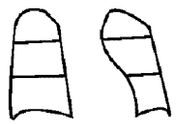
Date of X-ray

Findings_____



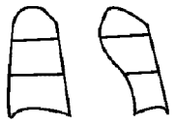
Date of X-ray

Findings_____



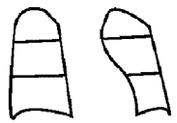
Date of X-ray

Findings_____



Date of X-ray

Findings_____



Date of X-ray

Findings_____

*ECG to be done daily (first two weeks), weekly (for 3 months) then monthly

Patient's name:_____

Initial Weight: _____kgs Height:_____cms

Weight band:

☐<16 Kg ☐ 16-25 Kg ☐ 26-45 Kg ☐ 46-70 Kg ☐>70 Kg

Date of starting intensive phase: _____

Date of starting continuation phase:_____

Details of rchange		
Date	Changed regimen	Reason for change

Drug Susceptibility Testing (DST) Results						
Drug	Date of specimen collection &type of DST (LJ/LC/LPA/CBNAAT)					
	Diagnosis	Month___	Month___	Month___	Month___	Month___
S						
H1						
H2						
R						
E						
Z						
Km						
Am						
Cm						
Lfx						
Mfx (0.5)						
Mfx(2.0)						
Eto						
PAS						
LZD						
CFZ						

ADMINISTRATION OF DRUGS (one line per month) **Patient's Name:_____**

Month/Yr	Day																													Weight in kg
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	

Mark in the boxes: ✓= directly observed; ✓ Unsupervised; = ◯ gs not taken; X=initiation of new box; Recording of CP should start from fresh line.

Month/Yr	Day																													Weight in kg
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	

Mark in the boxes: ✓= directly observed; ✓ = unsupervised; ◯ = drugs not taken; X=initiation of new box; Recording of CP should start from fresh line.

Date of retrieval action	By whom	Who contacted	Reason for missed doses	Outcome of retrieval action

Date of adverse drug reaction	Details of symptoms	Action taken

Treatment outcome	Date	Remarks
Cured		
Treatment completed		
Died		
Failed–Culture non conversion		
Failed – Culture reversion		
Failed – Additional drug resistance		
Failed – Adverse Drug Reaction		
Lost to follow up		
Regimen Change		
In remarks column, provide cause of death, reason for lost to follow up, latest TB no. in case of failure and put on treatment further		

Comments:

_____

_____

_____

_____

Name & Signature of Treating Physician:

_____

Post treatment follow up clinical & sputum				
Follow up	Clinical	Sputum	CXR	Impression
6 months of Rx				
12 months of Rx				
18 months of Rx				
24 months of RX				

RNTCP PMDT TB identity card

Name: _____

Address:_____

_____

_____

Contact No: _____

PMDT TB number:_____

PMDT NIKSHAY ID:_____

DR TB Centre: _____

District: _____

TB Unit: _____

DOT Centre:_____

Name of Treatment Supporter:

_____

Contact Number of Treatment Supporter:

_____

Treatment regimen: ☐ Regimen for H mono/poly resistant TB
☐ Regimen for MDR/RR TB
☐ Regimen for MDR/RR-TB + FQ/SLI resistance
☐ Regimen for XDR TB
☐ Regimen with Bedaquiline for MDR-TB + FQ/SLI resistance
☐ Regimen with Bedaquiline for XDR-TB
☐ Regimen with Bedaquiline for failures of regimen for MDR-TB ± FQ/SLI resistance
☐ Regimen with Bedaquiline for failures of regimen for XDR-TB
☐ Regimen for mixed pattern resistance

☐ CPT ☐ ART ☐ Diabetic ☐ Smoker

Date of starting treatment: (DD/MM/YYYY)

_____

Culture follow-up results			
Month __		Month __	
Month __		Month __	
Month __		Month __	
Month __		Month __	
Month __		Month __	
Month __		Month __	
Month __		Month __	

Treatment outcome: _____

Date:_____

Appointment dates

_____

_____

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In case of side effects or queries please contact

Name and contact number:

_____

_____

REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME

Referral / Transferform for treatment Serial Number

*To be filled **in** triplicate. One copy to be sent to the DTO receiving the patient, one copy to the health facility where the patient is referred to, and one copy to the patient*

Name and address of referring health facility _____

Contact Number and e-mail address of referring health facility: _____

Name and address of health facility to which patient is referred _____

_____

Name of patient_____ **Age**_____ **Sex M F TG**

Complete Address_____

_____**Contact no.**_____

Patient detail	
Site of disease ☐ Pulmonary ☐ Extra Pulmonary, Site _____ **Type of Patient** ☐ New ☐ Recurrent ☐ Transfer in ☐ Treatment After Failure ☐ Treatment After LFU ☐ Others, previously treated (Specify)_____ **Basis of Diagnosis** ☐ Microbiologically confirmed ☐ Clinical TB **H/O of ATT:** ___ months of treatment ___ months since end of last episode	**Diagnosis details** Date of diagnosis: __/__/___ Name of laboratory: Type of test: ZN / FM / CBNAAT / Culture Result : _____ TB notification number:_____ **HIV Status:** ☐ R ☐ NR ☐ Unknown **DST Status:** ☐ Rif Sensitive ☐ Rif Resistant ☐ Unknown, if unknown **Sample sent for DST to** _____ Date: __/__/__ **Treatment regimen:** ☐New☐Previously Treated **Date of treatment initiation: :** __/__/__ **Number of doses:**_____

Referred for:

- ☐ Initiation of treatment
- ☐ Adverse drug reaction (give details) _____
- ☐ Transfer out (give details)_____
- ☐ Any other (give details)_____

Name and designation of the referring doctor_____

Date referred

----------✂----------✂----------

Serial Number_____

For use by the health facility where the patient has been referred

Name of receiving health facility_____ Name of TB Unit and District_____

Name of patient _____ TB No (if available)_____

Age_____ Sex M ☐ F ☐ Date of receipt of patient_____

Date of initiation of treatment _____Treatment regimen_____ _____

Result of End IP specimen examination _____ Date of end IP specimen examination _____

Treatment outcome _____Date of treatment outcome _____

Signature_____Designation_____Date_____

This portion of the form has to be sent back to the referring unit as soon as the patient has been initiated on RNTCP treatment

Annexure 15 H

RNTCP PMDT Referral for treatment form

(Fill in duplicate. Send one copy to the concerned facility receiving the patient, and file the duplicate.)
Name and address of referring unit (District TB Centre/DR TB Centre):_____
e-mail address of referring unit: _____
Name of the facility where patient is referred: _____
Name of patient: _____ Age:_____ Gender: _____
Complete address:_____

Patient detail

Disease classification: ☐ Pulmonary
☐ Extra pulmonary (site_____)

Type: ☐ New ☐ Recurrent ☐TA LFU ☐ Failure ☐ Others

Reason for testing:
☐ New ☐ Previously Treated

☐ Presumptive TB
☐Private referral
☐ Presumptive NTM
☐Presumptive MDR-TB
☐ At diagnosis
☐ Contact of MDR/RR TB
☐ Follow up Sm+ve
☐ Private referral
☐Presumptive H mono/poly
☐ Presumptive XDR-TB
☐ MDR/RR TB at diagnosis☐ = 4 months culture positive☐ 3-monthly for persistent culture positives (treatment month _____)☐ Culture reversion☐ Failure of MDR/RR-TB regimen☐ Recurrent case of second line treatment

Latest TB No:_____

Latest regimen:
☐Regimen for INH mono/poly resistant TB
☐Regimen for MDR/RR TB
☐Regimen for MDR/RR-TB + FQ/SLI resistance ☐Regimen for XDR TB ☐Regimen with Bedaquiline for MDR-TB + FQ/SLI resistance
☐Regimen with Bedaquiline for XDR-TB
☐Regimen with Bedaquiline for failures of regimen for MDR-TB±FQ/SLI resistance
☐Regimen with Bedaquiline for failures of regimen for XDR-TB
☐Regimen for mixed pattern resistance

Sputum, culture and DST details

Date of culture result: __/__/___
Date of DST/LPA/CBNAAT result: __/__/___
DST/LPA/CBNAAT result* :
☐ S ☐ H1☐ H2☐ R ☐ E ☐ Z
☐ Km ☐ Am ☐ Cm
☐ Lfx ☐ Mfx (0.5) ☐ Mfx (2.0)
☐ Eto ☐ PAS ☐ LZD ☐ CFZ ☐ ___☐ ___☐___
(* Tick the drugs to which resistance is demonstrated)

DR TB treatment details

PMDT NIKSHAY ID: _____

DR TB Centre:_____

Date of DR TB regimen initiation: : __/__/__

Number of doses:_____

Date of regimen change and details of change: _____
Past exposure to second-line a-ntiTB drugs: Drugs (duration)_____
HIV Status: Pos Neg Not known Date of CPT initiation:_____ Date of ART initiation:_____
Date of referral to DR-TB Centre / DTC: Day _____ Month _____ Year _____

Referred for:
Initiation of treatment
Adverse drug reaction (give details) _____
Transfer out (give details)_____
Ambulatory treatment (if the patient is referred to DTC)
Any other (give details)_____
Name and designation of the referring doctor_____

Reminder for the health facility where the patient has been referred

Please send an e-mail to the referring unit, informing the referring doctor of the date that the above-named pa tient reported at the receivinghealth facility.

Revised National Tuberculosis Control Programme – TB Notification Register Year ___________ PHI_________

TB notification no. (NIKSHAY)	Name (in full)	Age	Sex (M/F/TG)	Complete Address	Pin code	Mobile/Landline Number	Key population#	Type of patient*	Site (P/EP)	Regimen N/PT /Outside RNTCP	Weight at beginning of treatment	Microbiological confirmation test results				Basis of diagnosis other than Microbiological (CXR/Histopatho/ Cytology/ Clinical/ /Other, specify)	HIV Status± (P/N/U)	Diabetes Status^ (D/N/U)	Date of sample sent for DST (NO if not sent, NA if not applicable)	Result of DST@	Status of treatment ***	Date of treatment initiation	Dosage Frequency (Daily / Intermittent)
												Date	Lab Name	Test (ZN / FM / Culture / CBNAAT)	Results of Test#								
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* **Type of patient (use complete words)**
New, Recurrent, Failure, LFU, Other PT, Transferred in

 # Test of result
For Smear result – Grades for smear positive, NEG for smear negative
For GX result – MTB detected Rif Resistance, MTB detected Rif sensitive, MTB detected Rif Indeterminate, MTB not detected, Error, Invalid, No result
For Culture result – Grades for culture positive, NEG for culture negative

± HIV Status
HIV status as reported before or during TB treatment P – Positive, N – Negative, U – Unknown.

^Diabetes Status
D=Diabetes, N=NonDiabetes, U = Unknown

@ Sensitive= if sensitive to tested drugs, Name of drug if resistant to any – R= Rifampicin, H=Isoniazide, E=Ethambutol, Z=Pyrazinamide, S=Streptomycin Lx=Levofloxacin, Mx=Moxifloxacin, Km=Kanamycin, Cm=Capreomycin

*****Status of treatment-**
1. Initiated on First line treatment in the same Health Facility
2. Initiated on second line treatment in the same Health Facility
3. Initiated on treatment outside Health Facility
4. Treatment initiated outside RNTCP
5. Incomplete/ incorrect address
6. Died
7. Migrated & untraceable
8. Repeat diagnosis
9. Patient already on treatment/ Follow up patient
10. Wrong diagnosis
11. Referred for treatment with pending feedback
12. Other

#Key population
PLHIV/Diabetes/Contact/Miner/Prison inmate/Health worker/Migrant/Refugee/Urban slum/Other, specify_____

1

Revised National Tuberculosis Control Programme – TB Notification Register Year_____ PHI_____

Follow-up smear examinations										Treatment Outcome#		If HIV-Pos		Post treatment follow up														Treatment supporter details		Remarks
End of IP					End of Treatment Exam									At 6 months Date____				At 12 months Date____				At 18 months Date____				At 24 months Date____						
Date	DMC Name	Smear result	Date of sample collected for DST	Result of DST@	Date	DMC Name	Smear results	Date of sample collected for DST	Result of DST@	Outcome	Date	CPT (y/n) date	ART (y/n) date	Symptoms*	CXR	Smear	Culture	Symptoms	CXR	Smear	Culture	Symptoms	CXR	Smear	Culture	Symptoms	CXR	Smear	Culture	Name	Designation	

Treatment Outcome –
Cured, Treatment Completed, Died, Lost to follow up, Failure, Not evaluated or Treatment change

± **Additional treatments if patient HIV-positive**
Required only for patients known to be HIV positive. If provided by any source during TB treatment, enter "Y" and approximate date. If not provided / unknown, enter "N".
***Symptoms-** Mention predominant system- Cough-C, Fever-F, Haemoptysis-H, Weight loss-W, Night Sweat - N Others-O, No symptoms - NS

Annexure 15J

RNTCP PMDT Treatment Register

Month _____Quarter _____ Year _____ District: _____ C-DST Lab: _____ DR-TB Centre:_____ State: _____

PMDT TB No	PMDT NIKSHAY ID	CDL NIKSHAY ID	Patient's name in full	Gender (M/F/TG)	Age in yrs	Complete address & mobile number	Name of health facility, TU, district	Reason for Testing @	Site of Disease (P/EP)	Type (New, Recurrent , TALFU, Failure, Others)	DST Details																			
											Type (LJ/LC/ LPA/ CBNAAT)	Date of DST	Results																	
													S	H	R	E	Z	Km	Am	Cm	Lfx	Mfx (0.5)	Mfx (2)	Eto	PAS	Lzd	Cfz	_____	_____

@ Presumptive TB – 1; Private referral – 2; Presumptive NTM – 3;

@ Presumptive MDR TB, At diagnosis–4; Contact of MDR/RR TB – 5; Follow up Sm+ve at end IP – 6; private referral – 7; Discordance resolution – 8; Presumptive H mono/poly –9; MDR/RR TB at diagnosis – 10; ≥ 4 months culture positive –11; 3-monthly for persistent culture positives –12; Culture reversion –13; Failure of MDR/RR-TB regimen –14; Recurrent case of second line treatment –15

Type of DR TB Patient RRTB/MDRTB/XDR TB	DRTB Regimen #	Date of Treatment initiation	Culture and DST Results at initiation and during DR TB Treatment (Treatment months)																														TB/HIV Collaborative activities					Final Treatment Outcome	Remarks
			0	3	4	5	6	7	9	12	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	Date of Test	PID No	HIV Status	Date of CPT initiation	Date of ART initiation		
			Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy	Culture dd/mm/yy							

#Cases put on:Regimen for H mono/poly resistant TB–**1**; Regimen for MDR/RR TB –**2**; Regimen for MDR/RR-TB + FQ/SLI resistance –**3**; Regimen for XDR-TB –**4**; Regimen with Bedaquiline for MDR-TB + FQ/SLI resistance–**5**; Regimen with Bedaquiline for XDR-TB–**6**; Regimen with Bedaquiline for failures of regimen for MDR-TB ± FQ/SLI resistance–**7**; Regimen with Bedaquiline for failures of regimen for XDR-TB – **8**; Regimen for mixed pattern resistance – **9**

Annexure 15 K

TB Laboratory Register

Lab. Serial No.	Date of collection of first specimen	Name in Full	Sex M/ F/TG	Age	Complete address (for diagnosis patients) Phone No.	Key Population	Name of referring health facility (PHI/ICTC/ART/Medical College / Private Others, specify)	Reasons for Examination								Type of specimen	Visual appearance	
								Presumptive TB / RE / Presumptive NTM	Predominant symptom & its duration	History of >1 month ATT (Yes/No)	Follow-up						a	b
											Nikshay ID	Regimen New / Previously Treated	Month	Post Treatment follow up month				

Notes

1. a- stands for supervised spot sample, b- stands for early morning sample
2. Remarks column can include date of starting treatment, treatment regimen, TB no., referral details with date, remarks on un blinded rechecking, etc
3. Visual appearance- mention M, B, or S., Mucopurulent, Blood stained or Saliva
4. Predominant symptoms: Cough-C, Fever-F, Haemoptysis-H, Weight loss-W, Night Sweat - N Others-O, No symptoms - NS
5. Key population - ☐Contact of TB/DRTB case ☐ Diabetes ☐ Tobacco ☐ Smoker ☐ Prison inmates ☐ Miner ☐ Migrant ☐ Refugee ☐ Urban slum ☐ Health-care worker ☐Other (specify) _____
6. Sensitive= if sensitive to tested drugs, Name of drug if resistant to any – R= Rifampicin, H=Isoniazide, E=Ethambutol, Z=Pyrazinamide, S=Streptomycin Lx=Levofloxacin, Mx=Moxifloxacin, Km=Kanamycin, Cm=Capreomycin
7. Duration of predominant symptoms should be recorded in days

Results		Date of Result	HIV status (Reactive / Non Reactive / Unknown)	Diabetic status (Diabetic /Non Diabetic / Unknown)	Sample for DST sent (Y/N) with date	DST result (write the drugs to which resistance is demonstrated)	NIKSHAY ID (notification no.)	Treatment initiation details (TB No. & TU details)/ Referral for treatment	Signature	Remarks
a	b									

Annexure 15 L

TB Laboratory Register

Lab. Serial No.	Date of collection of first specimen	Name in Full	Sex M/ F/TG	Age	Complete address (for diagnosis patients) Phone No.	Key Population	Name of referring health facility (PHI/ICTC/ART/Medical College / Private Others, specify)	Reasons for Examination								Type of specimen	Visual appearance	
											Follow-up						a	b
								Presumptive TB / RE / Presumptive NTM	Predominant symptom & its duration	History of >1 month ATT (Yes/No)	Nikshay ID	Regimen New / Previously Treated	Month	Post Treatment follow up month				

Notes

1. a- stands for supervised spot sample, b- stands for early morning sample
2. Remarks column can include date of starting treatment, treatment regimen, TB no., referral details with date, remarks on un blinded rechecking, etc
3. Visual appearance- mention M, B, or S., Mucopurulent, Blood stained or Saliva
4. Predominant symptoms: Cough-C, Fever-F, Haemoptysis-H, Weight loss-W, Night Sweat - N Others-O, No symptoms - NS
5. Key population - ☐Contact of TB/DRTB case ☐ Diabetes ☐ Tobacco ☐ Smoker ☐ Prison inmates ☐ Miner ☐ Migrant ☐ Refugee ☐ Urban slum ☐ Health-care worker ☐Other (specify) _____
6. Sensitive= if sensitive to tested drugs, Name of drug if resistant to any – R= Rifampicin, H=Isoniazide, E=Ethambutol, Z=Pyrazinamide, S=Streptomycin Lx=Levofloxacin, Mx=Moxifloxacin, Km=Kanamycin, Cm=Capreomycin
7. Duration of predominant symptoms should be recorded in days

RNTCP Laboratory Register for Culture, CBNAAT and Drug Susceptibility Testing

Rapid DST Results						Culture Results			Standard DST Results (R/S)																				Reporting of results		
Test performed (LPA/CBNAAT)	Date of receipt & CDL NIKSHAY ID	Valid* (Y/N)	TB † (Y/N)	RIF ‡ (R / S / I / N A)	INH (R/S/NA)	Type (LJ/LC)	CDL NIKSHAY ID	Results §	Type (LJ/LC)	Date of receipt & CDL NIKSHAY ID	Streptomycin	Isoniazid 1	Isoniazid 2	Rifampicin	Ethambutol	Pyrazinamide	Kanamycin	Amikacin	Capreomycin	Levofloxacin	Moxifloxacin (0.5)	Moxifloxacin (2.0)	Ethionamide	PAS	Linezolid	Clofazimine	Other _____	Other _____	Other _____	Date of reporting culture result	Date of reporting DST result	Remarks

* **Valid = Y** if both Amplification Control (AC) band & Conjugate Control (CC) band present; if either are missing, record **N**, and record no additional LPA results for this specimen.

† **TB = Y if** M. tuberculosis (TUB) band on LPA strip confirming identity as M. Tb or MTB Detected in CBNAAT, **N** if no TUB band on LPA strip or MTB Not Detected in CBNAAT

‡ **R** = Resistant, **S** = Sensitive, I = Indeterminate, **NA** = no result, judged by no locus control band on LPA strip for *rpo-B* (RIF), or for *inh-A* or *kat-G* (INH) or for *gyr-A* or *gyr-B* for FLQ or *eis* for ETH, or rrs for SLI. In case of CBNAAT, specify for NA, i.e. Error, Invalid, No Result

§ **Negative** = no growth, **Conta** = contaminated, **NTM** = Non-Tuberculosis Mycobacteria/fast grower, **3+** = confluent growth, **2+** = >100 colonies, **1+** = 10–100 colonies; **Sc#**Scanty<10 . Positive culture results should only be reported after identity for *M. tuberculosis* is confirmed with PNB, Niacin, Catalase, Rapid Immunoassay, or other methods.