Form 1. Presumptive TB Masterlist

Name of Facility: _____

Province/ HUC: _____

Region: _____

Cohort: _____

	Date of Consult MM/DD/YYYY	Patient's Full Name SURNAME, Given Names Name Extension and Middle Name	Age	Sex M/ F	Complete Address and Contact Number	Name of Referring Facility/ Unit/ Physician/ Health worker	Mode of Screening P/A/I/E	PRESUMPTIVE TB?	
								Presumptive DS-TB	Presumptive DR-TB
								Check [✓] one	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	
1								[ ]	[ ]
2								[ ]	[ ]
3								[ ]	[ ]
4								[ ]	[ ]
5								[ ]	[ ]
6								[ ]	[ ]
7								[ ]	[ ]
8								[ ]	[ ]
9								[ ]	[ ]
10								[ ]	[ ]
11								[ ]	[ ]
12								[ ]	[ ]
13								[ ]	[ ]
14								[ ]	[ ]
15								[ ]	[ ]

	Sputum Examination		Chest X-ray	Tuberculin Skin Test	Diagnosis			Action Taken/ Referred To and Status	Remarks
	Xpert MTB/RIF	Smear Microscopy or TB LAMP			Active TB	TB Infection	Not TB		
	RESULT (SEE LEGEND) AND DATE OF COLLECTION (MM/DD/YYYY)		RESULT/ IMPRESSION AND DATE OF EXAMINATION (MM/DD/YYYY)	RESULT AND DATE OF EXAMINATION (MM/DD/YYYY)	DATE NOTIFIED (MM/DD/YYYY) AND CASE NUMBER		✓		TYPE OF SPECIMEN IF PRESUMPTIVE EP-TB, OTHER DIAGNOSTIC TESTS, TB CASE NUMBER OF INDEX, ETC.
	(9)		(10)	(11)	(12a)	(12b)	(12c)	(13)	(14)
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

	Date/s	Mode of Screening A/ I	Number Screened by CXR	Number of Presumptive TB Identified	Remarks TARGET RISK GROUPS, TARGET AREA, ORGANIZER
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

	Date/s	Mode of Screening A/ I	Number Screened by CXR	Number of Presumptive TB Identified	Remarks TARGET RISK GROUPS, TARGET AREA, ORGANIZER
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					
32					
33					
34					
35					
36					
37					
38					
39					
40					

	Field	Definition	Format or Legend
1	Date of Consult	Date patient was seen or identified as a presumptive TB	All dates in **MM/DD/YYYY**
2	Patient's Full Name	Patient's legal full name	SURNAME in capital letters, Given Names, Name Extension, and Middle Name
3	Age	Patient's completed years as of date of consult	**NN** in years if at least 1 year old; **NNm** (for completed months) if less than 0
4	Sex	Patient's sex	**M** - male; **F** - female
5	Complete Address and Contact Number	Patient's contact information for tracking and follow-up purposes	House Number, Street and Village Name, and Baranggay/ District if patient is within facility's catchment; Otherwise, put complete address including Municipality, City, Province, and Zip Code Mobile Number 09xx-xxxxxxx and Landline Number xxxx-xxxx; add area code if patient is from outside the facility's catchment
6	Name of Referring Facility/ Unit/ Physician/ Health worker	Name of Facility, Unit, Physician, or Health worker that referred patient	**WI** if walk-in; Identifying name of facility, unit, physician, or healthworker that/ who referred the patient
7	Mode of Screening	Approach done in finding the patient (choose one only)	**P** - Passive Case Finding; **A** - Active Case Finding; **I** - Intensive Case Finding; **E**- Enhanced Case Finding
8	Presumptive TB?	Patient's risk classification based on interview (choose one only)	**Presumptive DS-TB** **Presumptive DR-TB** - high risk for MDR-TB (previously treated for TB, new TB cases that are contacts of confirmed DR-TB cases, or non-converter among patients on DS-TB regimens)
9	Sputum Examination	Laboratory tests done to test the patient's sputum (fill-up all that apply)	If extra-pulmonary, indicate type of specimen in Remarks column
		Xpert MTB/RIF Test Result and Date of Sputum Collection	**T** - MTB detected Rifampicin resistance not detected, **RR** - MTB detected Rifampicin resistance detected, **TI** - MTB detected, Rifampicin resistance indeterminate, **N** - MTB not detected, **I** - Invalid/ No result/ Error; **Not Done** Date in **MM/DD/YYYY**
		Smear Microscopy Test Result and Date of Sputum Collection	**0** - no AFB seen / no AFB onserved in 1 length **+n** - n AFB seen in 1 length / 5-49 AFB in 1 length / 3-24 AFB in 1 length **1+** - 10-99 AFB seen in 1 length / 3-24 AFB in 1 field / 1-6 AFB in in 1 field **2+** - 1-10 AFB/ OIF, at least 50 fields / 25-250 in 1 field / 7-60 in 1 field **3+** - >10 AFB/ OIF, at least 20 OIF / > 250 in 1 field / >60 in 1 field **Not Done** or **N/A** Date in **MM/DD/YYYY**
		TB LAMP Test Result and Date of Sputum Collection	**P** - MTB detected, the sample fluoresce under the UV light **N** - MTB not detected, the sample did not fluoresce under the UV light **I** - Sample with incomplete fluorescence as compared to the positive control Date in **MM/DD/YYYY**
10	Chest X-ray	Chest X-ray Results and Date of Examination	CXR impression unless facility physician requires otherwise; Indicate **"Not Done"** or **"Not Available"** as applies Date in **MM/DD/YYYY**
11	Tuberculin Skin Test	Turbeculin Skin Test Results and Date of Examination	**NN** in mm; Indicate **"Not Done"** or **"N/A"** as applies Date in **MM/DD/YYYY**
12	Diagnosis	Identification of the patient's illness (choose one only)	
12a		if Active TB Disease, Date of Notification	Indicate date in **MM/DD/YYYY** Record 4a for Notification only, 4b for DS-TB, or 4c if DR-TB was opened and TB Case Number
12b		if TB Infection, Date of Notification	Indicate date in **MM/DD/YYYY** Record 4d was opened and TPT Case Number, Put a check mark if treatment was not started
12c		if Not TB	Put a check mark
13	Action Taken/ Referred To and Status	Post-diagnosis actions taken including referral to another facility	Indicate name of facility/unit/physician where patient was referred to, date of referral in **MM/DD/YYYY** and outcome of referral (**accepted** or **lost**) If Masterlist is used as a Hospital Referral Logbook, indicate here reason/s of referral
14	Remarks	Other notes on the patient	Type of specimen collected if Presumptive EP-TB; if close contact, indicate TB Case Number of Index; if Other Diagnostic Test is available indicate name of test, date of examination in **MM/DD/YYYY** and results including unit of measure