**TB Referral CRFs for Children**

**I. TB Referral CRF**

**Note to DMC:** this CRF is for participants referred to a clinic based on “TB Referral Guidelines” criteria

1. Date of referral: (DD/MM/YYYY)

2. Reason for referral: □Cough □Fever □Night sweats □Weight loss □Fatigue □Household Contact with TB □Other

3. If other, specify: (free text)

4. Clinic names:  □Bontleng □Julia Molefe □Phase2 □BH2 □Nkoyaphiri □Mogoditshane □Lesirane □Old Naledi □BH3 □GWest □BH1 □Sebele □Other

5. If other, specify: (free text)

**II. TB Referral Outcomes CRF**

**Note to DMC**: this CRF is for participants who completed the “TB referral CRF,” to be completed at the next quarterly call.

1. Did participant go to clinic for TB evaluation? □Yes □No □Other

1. If Yes to Q1, proceed to Q2
2. If “No” to Q1, skip to Q10

2. Clinic name for referral: □Bontleng □Julia Molefe □Phase2 □BH2 □Nkoyaphiri □Mogoditshane □Lesirane □Old Naledi □BH3 □GWest □BH1 □Sebele □Other

3. If other, specify: (free text)

4. What diagnostic tests were performed for TB (select all that apply) □=Chest Xray □= Sputum sample □= Stool sample □= Urine test (LAM) □=Skin test (TST/Mantoux) □= Blood test (quantiferon) □= none □= other

1. Question 5: if other, specify test and result (free text)
2. **Note to DMC:** if anything other than “none” is checked on question 4, then require a response to the corresponding diagnostic test under question 6. (for example, if ‘Chest X-ray’ is a response to Q4, then Q6a Chest Xray results is required. If “none,” proceed to question 7
3. **Note to DMC:** allow multiple answers for Q4

6. Results:

1. Chest Xray Results: □ positive □ negative □ pending □ not received
2. Sputum sample Results: □ normal □ abnormal □ pending □ not received
3. Stool sample Results: □ positive □ negative □ pending □ not received
4. Urine test Results: □ positive □ negative □ pending □ not received
5. Skin Test Results: □ positive □ negative □ pending □ not received
6. Blood Test Results: □ positive □ negative □ pending □ not received
7. Other Result: □ positive □ negative □ pending □ not received

7. Was your child diagnosed with TB? □Yes □No □Awaiting results □Other(please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_(free text)

a. If “Yes” to Q7, proceed to Q8

b. If “No” to Q7, proceed to Q9

c. If “Awaiting results” or “Other,” CRF complete

8. Was your child started on TB treatment (consists of four or more drugs taken over several months)? □Yes □No □Other (please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_(free text)

a. End of CRF

9. Was your child started on TB preventative therapy (such as isoniazid or rifapentine/isoniazid for several months)? □Yes □No □Other(please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_(free text)

a. End of CRF

10. Reasons not able to go to TB clinic for evaluation (select all that apply):

□=temporarily out of study area

□=participant does not have transport fares

□=unable to attend due to school, exams or tests

□=participant/caregiver has work/home emergency issues

□=participant/caregiver cannot be released from work

□=participant is in isolation due to COVID-19 or another infection

□=participant/caregiver is not well

□= other(please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_(free text)

**Note to DMC:** if no to Q1, refer patient back to clinic and complete “TB referral CRF.”