**TB Screening in INFANT/CHILDREN/ADOLESCENTS in the FLOURISH Study**

**I. TB Screening CRF**

Note to DMC: to be asked at Quarterly Call Visits to all children (on each dashboard)

***Note to Clinic staff****:*

*A) Ask about recent symptoms. If symptoms resolved, unlikely to be TB.*

1. Does your child currently have any cough? □Yes □No □Unknown
	1. If Yes to Q1, proceed to Q2
	2. If “No” or “Unknown” to Q1, skip to Q3
2. How long has this cough lasted? □< 2 weeks □ $\geq $2 weeks
3. Does your child currently have a fever? □Yes □No □Unknown
	1. If Yes to Q3, proceed to Q4
	2. If “No” or “Unknown” to Q3, skip to Q5
4. How long has this fever lasted? □< 2 weeks □ $\geq $2 weeks
5. Is your child currently experiencing night sweats? (\*\*Night sweats is defined as waking up with your bed clothing soaked – enough to require the bed clothing to be changed) □Yes □No □Unknown
	1. If Yes to Q5, proceed to Q6
	2. If “No” or “Unknown” to Q5, skip to Q7
6. How long have the night sweats lasted? □< 2 weeks □ $\geq $2 weeks
7. Since we last spoke with you, has your child have any weight loss (or no weight gain for a child who is less than 12 years of age)? □Yes □No □Unknown
	1. If Yes to Q7, proceed to Q8
	2. If “No” or “Unknown” to Q7, skip to Q9
8. How long has the weight loss (or no weight gain) lasted? □< 2 weeks □ $\geq $2 weeks

**Q9 is only for children** $\leq $ **12 Years of age:**

1. Does your child have fatigue or reduced playfulness that has lasted $\geq $2 weeks? □Yes □No □Unknown
2. Since the last time you spoke with FLOURISH staff, has someone in your household been diagnosed with TB? □Yes □No □Unknown
	1. If “Yes” to Q10, proceed to Q11
	2. If “No” or “Unknown” to Q10, end of CRF.
3. Since the last time you spoke with FLOURISH staff, has your child been evaluated in a clinic for TB? □Yes □No □Unknown
	1. If “Yes” to Q11, proceed to Q12
	2. If “No” or “Unknown” to Q11, end of CRF.
4. What was the date of the clinic visit? (DD/MM/YYYY)
5. What diagnostic tests were performed for TB? (allow multiple responses) □=Chest Xray □= Sputum sample □= Stool sample □= Urine test (LAM) □= Skin test (TST/Mantoux) □Blood test (quantiferon) □= none □= other
6. If “Other”, specify test and result (free text)

**Note to DMC:** If a diagnostic test (any other than “none”) is checked on Q13, then require a response corresponding test type result (example: If “Chest Xray” was selected above, then Q15 “Chest Xray Result” is required. If the response to Q13 is “none,” proceed to **Q22**

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

**Note to DMC**: If results in Q15-21 are pending, make this CRF available to provide results in the next quarterly call P

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

a. If “Yes” to Q22, proceed to Q23

b. If “No” to Q22, proceed to Q24

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

1. 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

1. 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