Patient Name: State Case Number:

RVCT Investigation Record

Demographics

First Name	Middle Name	Patient Address (Street\Apt #)	City

Last Name	Age	7. DOB	State	Zip	County	Census Tract

Current Sex	8. Sex at Birth	Pregnancy Status	Country	Residence Within City Limits
☐Male ☐Female ☐Unk	☐Male ☐Female ☐Unk	☐Yes ☐No ☐Unk		☐Yes ☐No ☐Unk

Home Number	Cell Number	Work Number	Ext

9. Ethnicity
☐Hispanic or Latino
☐Not Hispanic or Latino ☐Unknown

10. Race
☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐White
☐Native Hawaiian or Other Pacific Islander ☐Other ☐Not asked ☐Refused to Answer ☐Unknown

Specify American Indian/Alaska Native	Specify Native Hawaiian/Pacific Islander

Specify Asian	Specify Black/African American	Specify White

Administrative Information

1. Date Reported	2a. MMWR Week	2b.MMWR Year	Case Verification Category	Case Status

3. TB State Case Number (YYYY-GA-ABCD56789)

5. Case Already Counted by Another Reporting Area?
☐No ☐Counted by another US area ☐TB treatment initiated in another country

4. Local Case Number (YYYY-GA-ABCD56789)	Previously Reported State Case Number (YYYY-GA-ABCD56789)	Country of Verified Case

Initial Evaluation

11a. Country of Birth	11b. Eligible for US Citizenship or Nationality at Birth ☐Yes ☐No ☐Unk	Date of First US Arrival

11c. Countries of Birth for Primary Guardians	12a. Country of Usual Residence	12b. If NOT US Reporting Area, Has Patient Been in US for 90 Days or More ☐Yes ☐No ☐Unk

13. Status at TB Diagnosis
If deceased, complete question 43 ☐Alive ☐Dead

14. Initial Reason Evaluated for TB
☐Contact Investigation ☐Screening ☐Other, Specify:
☐TB Symptoms ☐Unknown

15a. Ever Worked As
(select all that apply) ☐Correctional Facility Employee ☐Healthcare Worker ☐Migrant/Seasonal Worker ☐Unknown ☐None

15b. Current Occupation Standardized	15b. Current Occupation	15b. Current Industry Standardized	15b. Current Industry

16. Risk Factors

Diabetic (at Diagnostic Evaluation) ☐Yes ☐No ☐Unk	Homeless (Past 12 Months) ☐Yes ☐No ☐Unk	Homeless (Ever) ☐Yes ☐No ☐Unk	Resident of Correctional Facility (Ever) ☐Yes ☐No ☐Unk

Resident of Correctional Facility (at Diagnostic Evaluation) ☐Yes ☐No ☐Unk	Resident of LTC Facility (at Diagnostic Evaluation) ☐Yes ☐No ☐Unk

17. If yes, type of facility
☐Federal Prison ☐Local Jail
☐Juvenile Correction Facility ☐State Prison
☐Other, Specify: ☐Unknown

18. If yes, type of facility
☐Alcohol and Drug Treatment Facility ☐Nursing Home
☐Hospital Based Facility ☐Residential Facility
☐Mental Health Residential Facility ☐Unknown
☐Other, Specify:

Patient Name: State Case Number:

16. Risk Factors

Injecting Drug Use (Past 12 Months) ☐Yes ☐No ☐Unk	**Noninjecting Drug Use** (Past 12 Months) ☐Yes ☐No ☐Unk	**Heavy Alcohol Use** (Past 12 Months) ☐Yes ☐No ☐Unk	**TNF Antagonist Therapy** ☐Yes ☐No ☐Unk
Viral Hepatitis (B or C Only) ☐Yes ☐No ☐Unk	**Post Organ Transplantation** ☐Yes ☐No ☐Unk	**End Stage Renal Disease** ☐Yes ☐No ☐Unk	**Other Immunocompromised** (other than HIV/AIDS) ☐Yes ☐No ☐Unk
Other Risk Factor ☐Yes ☐No ☐Unk	**Specify Other Risk Factor**		**20. Lived outside of US for More than 2 Months** ☐Yes ☐No ☐Unk

19. Current Smoking Status at Diagnostic Evaluation ☐Current Everyday Smoker ☐Current Someday Smoker ☐Former Smoker ☐Never Smoker ☐Smoker, Current Status Unknown ☐Unknown if Ever Smoked

21. Diagnostic Testing

HIV Status
☐Positive ☐Negative ☐Indeterminate ☐Not Done ☐Not Offered ☐Refused ☐Unknown ☐Test Done, Results Unknown
Collection Date _____ **Date Reported** _____

Tuberculin (Mantoux) Skin Test at Diagnosis
☐Positive ☐Negative ☐Indeterminate ☐Not Done ☐Not Offered ☐Refused ☐Unknown ☐Test Done, Results Unknown
Date Placed _____ **Date Read** _____ **MM of Induration** _____

Interferon Gamma Release Assay for Mycobacterium tuberculosis at Diagnosis
☐Positive ☐Negative ☐Indeterminate ☐Not Done ☐Not Offered ☐Refused ☐Unknown ☐Test Done, Results Unknown
Test Type ☐IGRA - TSpot ☐IGRA - Other ☐IGRA - QFT ☐IGRA - Unknown
Collection Date _____ **Date Reported** _____
Quantitative Result _____ **Quantitative Result Units** _____

Sputum Smear
☐Positive ☐Negative ☐Indeterminate ☐Not Done ☐Not Offered ☐Refused ☐Unknown ☐Test Done, Results Unknown
Collection Date _____ **Date Reported** _____

Sputum Culture
☐Positive ☐Negative ☐Indeterminate ☐Not Done ☐Not Offered ☐Refused ☐Unknown ☐Test Done, Results Unknown
Collection Date _____ **Date Reported** _____

Smear/Pathology/Cytology of Tissue or Other Bodily Fluids
☐Positive ☐Negative ☐Indeterminate ☐Not Done ☐Not Offered ☐Refused ☐Unknown ☐Test Done, Results Unknown
Test Type ☐Cytology ☐Pathology ☐Pathology/Cytology
Collection Date _____ **Date Reported** _____
Specimen Source _____

Culture of Tissue or Other Bodily Fluids
☐Positive ☐Negative ☐Indeterminate ☐Not Done ☐Not Offered ☐Refused ☐Unknown ☐Test Done, Results Unknown
Collection Date _____ **Date Reported** _____ **Specimen Source** _____

Nucleic Acid Amplification Test Result
☐Positive ☐Negative ☐Indeterminate ☐Not Done ☐Not Offered ☐Refused ☐Unknown ☐Test Done, Results Unknown
Collection Date _____ **Date Reported** _____ **Specimen Source** _____

Test Type	Specimen Source	Date Collected/ Placed	Date Reported/ Read	Test Result (Qualitative)	Quantitative Result	Result Units
				P N IN ND NO R U RU		
				P N IN ND NO R U RU		
				P N IN ND NO R U RU		

Diagnostic Test Type Options

HIV | CD4 Count| TST | Culture | Smear | NAA | IGRA-QFT | IGRA-Tspot |IGRA-Unknown | IGRA-Other | Cytology | Pathology | Pathology/Cytology Hemoglobin A1c | Fasting Blood Glucose | Other (specify)

Test Result Key

P – Positive | N – Negative | IN – Indeterminate | ND – Not Done
NO – Not Offered | R – Refused | U – Unknown
RU -Test Done, Result Unknown

Patient Name: State Case Number:

Test Type	Specimen Source	Date Collected/ Placed	Date Reported/ Read	Test Result (Qualitative)	Quantitative Result	Result Units
				P N IN ND NO R U RU		
				P N IN ND NO R U RU		
				P N IN ND NO R U RU		
				P N IN ND NO R U RU		
				P N IN ND NO R U RU		

Diagnostic Test Type Options	Test Result Key
HIV | CD4 Count| TST | Culture | Smear | NAA | IGRA-QFT | IGRA-Tspot |IGRA-Unknown | IGRA-Other | Cytology | Pathology | Pathology/Cytology Hemoglobin A1c | Fasting Blood Glucose | Other (specify)	P – Positive | N – Negative | IN – Indeterminate | ND – Not Done NO – Not Offered | R – Refused | U – Unknown RU -Test Done, Result Unknown

22. Chest Radiograph and Other Chest Imaging Results

Initial Chest X-Ray

☐Consistent with TB ☐Not Done
☐Not Consistent with TB ☐Unknown

X-Ray Date ______________

Evidence of Cavity ☐Yes ☐No ☐Unk

Evidence of Miliary TB ☐Yes ☐No ☐Unk

Initial Chest CT Scan

☐Consistent with TB ☐Not Done
☐Not Consistent with TB ☐Unknown

CT Scan Date ______________

Evidence of Cavity ☐Yes ☐No ☐Unk

Evidence of Miliary TB ☐Yes ☐No ☐Unk

Test Type	Date of Study	Result of Study	Evidence of Cavity	Evidence of Miliary TB
☐Chest X-Ray ☐CT Scan ☐PET ☐MRI ☐Other:		☐Consistent with TB ☐Not Done ☐Not Consistent with TB ☐Unknown	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
☐Chest X-Ray ☐CT Scan ☐PET ☐MRI ☐Other:		☐Consistent with TB ☐Not Done ☐Not Consistent with TB ☐Unknown	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
☐Chest X-Ray ☐CT Scan ☐PET ☐MRI ☐Other:		☐Consistent with TB ☐Not Done ☐Not Consistent with TB ☐Unknown	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk

Epidemiologic Investigation

26. Case Meets Binational Reporting Criteria ☐Yes ☐No ☐Unk

Which criteria were met (select all that apply)

☐Exposure to suspected product from Canada or Mexico
☐Has case contacts in or from Mexico or Canada
☐Other situations that may require binational notification or coordination of response
☐Potentially exposed while in Mexico or Canada
☐Potentially exposed by a resident of Mexico or Canada
☐Resident of Canada or Mexico

27. Case Identified During the Contact Investigation of Another Case ☐Yes ☐No ☐Unk

If yes, evaluated for TB during that contact investigation? ☐Yes ☐No ☐Unk

28. Contact Investigation Conducted ☐Yes ☐No ☐Unk

29. Linked State Case Number (YYYY-GA-ABCD56789)

1: ______ 2: ______ 3: ______ 4: ______

5: ______ 6: ______ 7: ______ 8: ______

Clinical History and Findings

23. Previously Diagnosed with TB Disease/LTBI ☐Yes ☐No ☐Unk

If YES, Complete Table Below. Provide only 1 response for LTBI. Multiple responses for TB are allowed.

Diagnosis Type	Date of Diagnosis	Previous State Case Number	Completed Treatment
☐ TB ☐ LTBI			☐Yes ☐No ☐Unk
☐ TB ☐ LTBI			☐Yes ☐No ☐Unk
☐ TB ☐ LTBI			☐Yes ☐No ☐Unk

24. Date of Illness Onset ______________

25. Sites of TB Disease

Primary Sites (Select all that apply)

☐Pulmonary (Lung)
☐Pleural
☐Lymphatic Cervical
☐Lymphatic Intrathoracic
☐Lymphatic Axillary
☐Lymphatic Other
☐Lymphatic Unknown
☐Laryngeal
☐Bone and/or Joint
☐Genitourinary
☐Meningeal
☐Peritoneal
☐Site not Stated
☐Other, Specify:

Secondary Sites:

Patient Name: State Case Number:

31. Initial Drug Regimen

30. Date Therapy Started

_____

32. If Initial Drug Regimen NOT RIPE/HRZE, Why Not?

☐Drug contraindication/interaction ☐Drug shortage
☐Drug susceptibility testing results already known ☐Suspected drug resistance
☐Unknown ☐Other, Specify:

Standard Regimen				
Isoniazid ☐Yes ☐No ☐Unk	**Rifabutin** ☐Yes ☐No ☐Unk	**Capreomycin** ☐Yes ☐No ☐Unk	**Other Quinolones** ☐Yes ☐No ☐Unk	**Delamanid** ☐Yes ☐No ☐Unk
Rifampin ☐Yes ☐No ☐Unk	**Rifapentine** ☐Yes ☐No ☐Unk	**Ciprofloxacin** ☐Yes ☐No ☐Unk	**Cycloserine** ☐Yes ☐No ☐Unk	**Clofazimine** ☐Yes ☐No ☐Unk
Pyrazinamide ☐Yes ☐No ☐Unk	**Ethionamide** ☐Yes ☐No ☐Unk	**Levofloxacin** ☐Yes ☐No ☐Unk	**Para-Aminosalicylic acid** ☐Yes ☐No ☐Unk	**Pretomanid** ☐Yes ☐No ☐Unk
Ethambutol ☐Yes ☐No ☐Unk	**Amikacin** ☐Yes ☐No ☐Unk	**Ofloxacin** ☐Yes ☐No ☐Unk	**Linezolid** ☐Yes ☐No ☐Unk	**Other Drug Regimen** ☐Yes ☐No ☐Unk
Streptomycin ☐Yes ☐No ☐Unk	**Kanamycin** ☐Yes ☐No ☐Unk	**Moxifloxacin** ☐Yes ☐No ☐Unk	**Bedaquiline** ☐Yes ☐No ☐Unk	**Specify:**

Genotyping And Drug Susceptibility Testing (Phenotypic)

33. Isolate Submitted for Genotyping ☐Yes ☐No ☐Unk

If yes, Accession Number

34. Was Phenotypic/Growth-Based Drug Susceptibility Testing Done? ☐Yes ☐No ☐Unk

Drug Name	Date Collected	Date Reported	Specimen Source	Result	Test Method (Optional)
Isoniazid				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Rifampin				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Pyrazinamide				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Ethambutol				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Streptomycin				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Rifabutin				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Rifapentine				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Ethionamide				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Amikacin				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Kanamycin				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Capreomycin				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Ciprofloxacin				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	

Drug Name Options

Isoniazid	Streptomycin	Amikacin	Levofloxacin	Cycloserine	Delamanid
Rifampin	Rifabutin	Kanamycin	Ofloxacin	Para-Aminosalicylic acid	Clofazimine
Pyrazinamide	Rifapentine	Capreomycin	Moxifloxacin	Linezolid	Pretomanid
Ethambutol	Ethionamide	Ciprofloxacin	Other Quinolones	Bedaquiline	Other (Specify)

Test Method Options

E-Test/MIC	Broth culture/MIC
Kirby-Bauer/Disk Diffusion	Agar dilution/MIC
	Other (specify)

Patient Name: State Case Number:

Genotyping And Drug Susceptibility Testing (Phenotypic)

Drug Name	Date Collected	Date Reported	Specimen Source	Result	Test Method (Optional)
Levofloxacin				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Ofloxacin				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Moxifloxacin				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Other Quinolones				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Cycloserine				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Para-Aminosalicylic acid				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Linezolid				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Bedaquiline				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Delamanid				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Clofazimine				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
Pretomanid				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	
				☐Resistant ☐Not Done ☐Susceptible ☐Unknown	

Drug Name Options

Isoniazid	Streptomycin	Amikacin	Levofloxacin	Cycloserine	Delamanid
Rifampin	Rifabutin	Kanamycin	Ofloxacin	Para-Aminosalicylic acid	Clofazimine
Pyrazinamide	Rifapentine	Capreomycin	Moxifloxacin	Linezolid	Pretomanid
Ethambutol	Ethionamide	Ciprofloxacin	Other Quinolones	Bedaquiline	Other (Specify)

Test Method Options

E-Test/MIC	Broth culture/MIC
Kirby-Bauer/Disk Diffusion	Agar dilution/MIC
	Other (specify)

Patient Name: State Case Number:

Genotyping And Drug Susceptibility Testing (Molecular)

35. Was Genotypic or Molecular Drug Susceptibility Testing Done? ☐Yes ☐No ☐Unk

	1	2	3	4
Gene Name				
Date Collected				
Date Reported				
Specimen Source				
Result	☐Mutation Detected ☐Mutation Not Detected ☐Unknown	☐Mutation Detected ☐Mutation Not Detected ☐Unknown	☐Mutation Detected ☐Mutation Not Detected ☐Unknown	☐Mutation Detected ☐Mutation Not Detected ☐Unknown
Nucleic Acid Change				
Amino Acid Change				
Indel	☐Deletion ☐Insertion ☐Indel ☐Unknown	☐Deletion ☐Insertion ☐Indel ☐Unknown	☐Deletion ☐Insertion ☐Indel ☐Unknown	☐Deletion ☐Insertion ☐Indel ☐Unknown
Test Type	☐Sequencing ☐Unknown ☐Non-sequencing ☐Other, Specify:	☐Sequencing ☐Unknown ☐Non-sequencing ☐Other, Specify:	☐Sequencing ☐Unknown ☐Non-sequencing ☐Other, Specify:	☐Sequencing ☐Unknown ☐Non-sequencing ☐Other, Specify:
	5	**6**	**7**	**8**
Gene Name				
Date Collected				
Date Reported				
Specimen Source				
Result	☐Mutation Detected ☐Mutation Not Detected ☐Unknown	☐Mutation Detected ☐Mutation Not Detected ☐Unknown	☐Mutation Detected ☐Mutation Not Detected ☐Unknown	☐Mutation Detected ☐Mutation Not Detected ☐Unknown
Nucleic Acid Change				
Amino Acid Change				
Indel	☐Deletion ☐Insertion ☐Indel ☐Unknown	☐Deletion ☐Insertion ☐Indel ☐Unknown	☐Deletion ☐Insertion ☐Indel ☐Unknown	☐Deletion ☐Insertion ☐Indel ☐Unknown
Test Type	☐Sequencing ☐Unknown ☐Non-sequencing ☐Other, Specify:	☐Sequencing ☐Unknown ☐Non-sequencing ☐Other, Specify:	☐Sequencing ☐Unknown ☐Non-sequencing ☐Other, Specify:	☐Sequencing ☐Unknown ☐Non-sequencing ☐Other, Specify:

36. Was the Patient Treated as an MDR TB Case Regardless of DST Result
If yes, complete MDR supplemental data form on page 6. ☐Yes ☐No ☐Unk

Patient Name: State Case Number:

Case Outcome

37. Sputum Culture Conversion Documented

☐Yes ☐No ☐Unk

If Yes, date specimen collected for FIRST consistently negative sputum culture

If No, reason for not documenting sputum culture conversion

☐No Follow-up Sputum and No Induction
☐No Follow-up Sputum Despite Induction
☐Patient Refused
☐Other, Specify:
☐Patient Lost to Follow-up
☐Died
☐Unknown

38. Moved During Therapy

☐Yes ☐No ☐Unk

If Yes, moved to where (select all that apply)

☐Out of State
☐Out of United States

If out of state, specify destination

Transnational Referral Made

☐Yes ☐No ☐Unk

If out of country, specify destination

39. Date Therapy Stopped

40. Reason Therapy Stopped or Never Started

☐Completed Treatment
☐Dying (treatment stopped due to imminent death)
☐Patient Choice (Uncooperative or Refused)
☐Adverse Treatment Event
☐Not TB
☐Other, Specify:
☐Died
☐Lost
☐Unknown

41. Reason TB Disease Therapy Extended >12 Months, if applicable (select all that apply)

☐Inability to Use Rifampin (Resistance, Intolerance, etc.)
☐Adverse Drug Reaction
☐Clinically Indicated for Reasons Other than Above
☐Failure
☐Nonadherence
☐Unknown
☐Other, Specify:

42. Treatment Administration (select all that apply)

☐ DOT (Directly Observed Therapy, in person)
☐ EDOT (Electronic DOT, via video call or other electronic method)
☐ Self-Administered

43. Did the Patient Die (either before diagnosis or at any time while being followed by TB program)

☐Yes ☐No ☐Unk

Date of Death

Did TB or Complications of TB Treatment Contribute to Death

☐Yes ☐No ☐Unk

Investigation Comments

Patient Name: State Case Number:

MDR TB Supplemental Surveillance Form

To be completed for all cases treated as MDR TB, regardless of DST results

1. History of Treatment Before Current Episode ☐Yes ☐No ☐Unk	2. Date MDR TB Therapy Started for Current Episode

3. Drugs ever used for MDR TB treatment

Drug Name	Length of Time Administered	Drug Name	Length of Time Administered	Drug Name	Length of Time Administered
Isoniazid	☐< 1 Month ☐≥1 Month ☐Not Used	**Capreomycin**	☐< 1 Month ☐≥1 Month ☐Not Used	**Delamanid**	☐< 1 Month ☐≥1 Month ☐Not Used
Rifampin	☐< 1 Month ☐≥1 Month ☐Not Used	**Ciprofloxacin**	☐< 1 Month ☐≥1 Month ☐Not Used	**Clofazimine**	☐< 1 Month ☐≥1 Month ☐Not Used
Pyrazinamide	☐< 1 Month ☐≥1 Month ☐Not Used	**Levofloxacin**	☐< 1 Month ☐≥1 Month ☐Not Used	**Pretomanid**	☐< 1 Month ☐≥1 Month ☐Not Used
Ethambutol	☐< 1 Month ☐≥1 Month ☐Not Used	**Ofloxacin**	☐< 1 Month ☐≥1 Month ☐Not Used		☐< 1 Month ☐≥1 Month ☐Not Used
Streptomycin	☐< 1 Month ☐≥1 Month ☐Not Used	**Moxifloxacin**	☐< 1 Month ☐≥1 Month ☐Not Used		☐< 1 Month ☐≥1 Month ☐Not Used
Rifabutin	☐< 1 Month ☐≥1 Month ☐Not Used	**Other Quinolones**	☐< 1 Month ☐≥1 Month ☐Not Used		☐< 1 Month ☐≥1 Month ☐Not Used
Rifapentine	☐< 1 Month ☐≥1 Month ☐Not Used	**Cycloserine**	☐< 1 Month ☐≥1 Month ☐Not Used		☐< 1 Month ☐≥1 Month ☐Not Used
Ethionamide	☐< 1 Month ☐≥1 Month ☐Not Used	**Para-Aminosalicylic acid**	☐< 1 Month ☐≥1 Month ☐Not Used		☐< 1 Month ☐≥1 Month ☐Not Used
Amikacin	☐< 1 Month ☐≥1 Month ☐Not Used	**Linezolid**	☐< 1 Month ☐≥1 Month ☐Not Used		☐< 1 Month ☐≥1 Month ☐Not Used
Kanamycin	☐< 1 Month ☐≥1 Month ☐Not Used	**Bedaquiline**	☐< 1 Month ☐≥1 Month ☐Not Used		☐< 1 Month ☐≥1 Month ☐Not Used

4. Date injectable medication was stopped	5. Was surgery performed to treat MDR TB? ☐Yes ☐No ☐Unk	Date of Surgery

6. Side Effects

Side Effect	Side Effect Experienced	When	Side Effect	Side Effect Experienced	When
Hearing Loss	☐Yes ☐No ☐Unk	☐During Treatment ☐At End of Treatment ☐Both	**Tinnitus**	☐Yes ☐No ☐Unk	☐During Treatment ☐At End of Treatment ☐Both
Liver Toxicity	☐Yes ☐No ☐Unk	☐During Treatment ☐At End of Treatment ☐Both	**Myalgia**	☐Yes ☐No ☐Unk	☐During Treatment ☐At End of Treatment ☐Both
Renal Dysfunction	☐Yes ☐No ☐Unk	☐During Treatment ☐At End of Treatment ☐Both	**Suicide Attempt or Ideation**	☐Yes ☐No ☐Unk	☐During Treatment ☐At End of Treatment ☐Both
Peripheral Neuropathy	☐Yes ☐No ☐Unk	☐During Treatment ☐At End of Treatment ☐Both	**Vision Change/Loss**	☐Yes ☐No ☐Unk	☐During Treatment ☐At End of Treatment ☐Both
Depression	☐Yes ☐No ☐Unk	☐During Treatment ☐At End of Treatment ☐Both		☐Yes ☐No ☐Unk	☐During Treatment ☐At End of Treatment ☐Both
Cardiac Abnormalities	☐Yes ☐No ☐Unk	☐During Treatment ☐At End of Treatment ☐Both		☐Yes ☐No ☐Unk	☐During Treatment ☐At End of Treatment ☐Both
Vestibular Dysfunction	☐Yes ☐No ☐Unk	☐During Treatment ☐At End of Treatment ☐Both		☐Yes ☐No ☐Unk	☐During Treatment ☐At End of Treatment ☐Both