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|  | **TB Cohort Review Presentation Form (v7)** | | | | | | | | | | | | | | | | |
|  | **1. Patient details** | | | | | | | | | | | | | | | | |
|  | Date form completed: 21/05/2016 | | | | | | | Case manager: *lkamwa* | | | | | | | | |  |
|  | Clinic: *BLACKPOOL VICTORIA HOSPITAL* | | | | | | | | | | | | | | | |  |
|  | HPU: *Cumbria & Lancashire HPU* | | | | | | | | | PCT: *BLACKPOOL PCT* | | | | | | |  |
|  | ETS no: *142879* | | | | | | | Date of notification: *21/06/2012* | | | | |  | | | |  |
|  | Age: *63* | | | | | | | Sex: *M* | | | | | Ethnic group: *White* | | | |  |
|  | UK born: *Yes* | | | | | | | Country of birth: | | | | | Entered UK (year): | | | |  |
|  | Referred to TB service by: | | | | | | | Date referred to TB Service: 21/05/2017 | | | | | Date 1st seen by any member of TB Service: 21/05/2017 | | | |  |
|  | No. of days between referral & 1st seen: 100 | | | | | | | Date treatment commenced: 21/05/2017 | | | | | Patient occupation: *Unemployed* | | | |  |
|  | **2. Clinical details** | | | | | | | | | | | | | | | | |
|  | Site of disease: Very long bit of text | | | | | | | | | | | | Pulmonary infection: *True* | | | |  |
|  | Initial sputum smear status: | | | | | | | Type of sputum: | | | | | Smear status (other than sputum):  Smear status other than sputum | | | |  |
|  | CXR / chest CT at diagnosis: | | | | | | | Culture at any site: | | | | | Drug sensitivities: | | | |  |
|  | HIV test offered: *False* | | | | | | | Outcome of HIV test: | | | | | Year of test: 1999 | | | |  |
|  | Previous BCG: *Not known* | | | | | | |  | | | | |  | | | |  |
|  | **3a. Risk factors for non-adherence - adults** | | | | | | | | | | | | | | | | |
|  | Standardized Risk Assessment completed: | | | | | | | | | Required Enhanced Case Management (ECM): | | | | | | |  |
|  | Problem alcohol use: *Unknown* | | | | | | | Unstable housing: *Unknown* | | | | | Problem drug use: *Unknown* | | | |  |
|  | Previous TB diagnosis: *No* | | | | | | | Imprisonment: *Unknown* | | | | | Mental health: | | | |  |
|  | Dual diagnosis: | | | | | | | MDR: | | | | | Non-adherence: | | | |  |
|  | Language barrier: | | | | | | | Gipsy / traveller: | | | | | Hard to reach group: | | | |  |
|  | Other:  Some other details | | | | | | | | | | | | | | | |  |
|  | **3b. Risk factors for non-adherence - children (<16 years old)** | | | | | | | | | | | | | | | | |
|  | Standardized Risk Assessment completed on child and main carer: | | | | | | | | | | | | Previous TB diagnosis: *No* | | | |  |
|  | Drug / alcohol use by parent / child: | | | | | | | Unstable housing: *Unknown* | | | | | Parental non-adherence: | | | |  |
|  | Previous LTBI treatment: | | | | | | | Child protection issues: | | | | | Hard to reach group: | | | |  |
|  | Mental health (parent / child): | | | | | | | Language barrier: | | | | | Gipsy / traveller: | | | |  |
|  | Other: Other risk factors…… | | | | | | | | | | | | | | | |  |
|  | **4. Treatment plan** | | | | | | |  | | | | |  | | | |  |
|  | Weekly supervised: | | | | | | | Urine test: | | | | | SAT: | | | |  |
|  | Tablet count: | | | | | | |  | | | | |  | | | |  |
|  | DOT required: | | | | | | | DOT from start of treatment: | | | | | % doses observed:  100 | | | |  |
|  | DOT offered: | | | | | | | If not from Rx start, DOT started: 21/05/2017 | | | | | % doses self-administered: 50 | | | |  |
|  | DOT refused: | | | | | | | No. of weeks on DOT: 100 | | | | | % doses missed: 25 | | | |  |
|  | **5. Treatment outcome at time of cohort** | | | | | | | | | | | | | | | |  |
|  | Completed treatment:  (if did not, ) | | | | | | | Reason for non completion: Too drunk | | | | | | | | |  |
|  | If still on TB medications: no. of completed weeks treatment 100  and likely to complete within  (time from treatment start date) | | | | | | | | | | | | | | | |  |
|  | If lost to FU, actions taken: FU actions taken | | | | | | | | | | | | | | | |  |
|  | **6. Contact screening (excluding incidents)** | | | | | | | | | | | | | | | |  |
|  |  | | | | Contacts screened by clinic | | | | Contacts referred elsewhere | | | | | **Notes from ETS:** | | |  |
|  | Identified: | |  | | 0 (adult) | | 1 (child) | | 2 (adult) | | | 3 (child) | |  | | |  |
|  | Assessed: | |  | | 4 (adult) | | 5 (child) | | 6 (adult) | | | 7 (child) | |  | | |  |
|  | Still under investigation: | |  | | (adult) | | 0 (child) | | 1 (adult) | | | 2 (child) | |  | | |  |
|  | No. with active disease: | |  | | 3 (adult) | | 4 (child) | | 5 (adult) | | | 6 (child) | |  | | |  |
|  | No. with LTBI: | |  | | 7 (adult) | | 8 (child) | | 9 (adult) | | | (child) | |  | | |  |
|  | No. started LTBI Rx: | |  | | 0 (adult) | | 1 (child) | | 2 (adult) | | | 3 (child) | |  | | |  |
|  | No. completed LTBI treatment: | |  | | 4 (adult) | | 5 (child) | | 6 (adult) | | | 7 (child) | |  | | |  |
|  | Discontinued LTBI treatment due to: | | Adverse FX: | | 8 (adult) | | 9 (child) | | (adult) | | | 0 (child) | |  | | |  |
|  |  | | Death: | | 1 (adult) | | 2 (child) | | 3 (adult) | | | 4 (child) | |  | | |  |
|  |  | | Moved: | | 5 (adult) | | 6 (child) | | 7 (adult) | | | 8 (child) | |  | | |  |
|  |  | | Refused: | | 9 (adult) | | (child) | | 0 (adult) | | | 1 (child) | |  | | |  |
|  | If any contact was a previous TB case (adequately treated), record ETS numbers: 18888, 99999, 99999, 100 | | | | | | | | | | | | | | | |  |
|  | Is the patient part of a cluster?   (if yes, ) | | | | | | | Cluster ID: dsklfjdsaklf;ajdskfl;dsa | | | | |  | | | |  |
|  | HPU incident meeting held?  (if yes, ) | | | | | | | HPZone No: 894320598430574389 | | | | |  | | | |  |
|  | **Space for additional notes:** | | | | | | | | | | | | | | | |  |
|  | Frédéric François Chopin (/ˈʃoʊpæn/; French: [fʁedeʁik fʁɑ̃swa ʃɔpɛ̃]; 1 March 1810 – 17 October 1849), born Fryderyk Franciszek Chopin,[n 1] was a Polish composer and virtuoso pianist of the Romantic era who wrote primarily for the solo piano. He gained and has maintained renown worldwide as a leading musician of his era, whose "poetic genius was based on a professional technique that was without equal in his generation."[1] Chopin was born in what was then the Duchy of Warsaw and grew up in Warsaw, which in 1815 became part of Congress Poland. A child prodigy, he completed his musical education and composed his earlier works in Warsaw before leaving Poland at the age of 20, less than a month before the outbreak of the November 1830 Uprising.  At 21 he settled in Paris. Thereafter, during the last 18 years of his life, he gave only some 30 public performances, preferring the more intimate atmosphere of the salon. He supported himself by selling his compositions and by teaching piano, for which he was in high demand. Chopin formed a friendship with Franz Liszt and was admired by many of his musical contemporaries, including Robert Schumann. In 1835 he obtained French citizenship. After a failed engagement to Maria Wodzińska from 1836 to 1837, he maintained an often troubled relationship with the French woman writer George Sand. A brief and unhappy visit to Majorca with Sand in 1838–39 was one of his most productive periods of composition. In his last years, he was financially supported by his admirer Jane Stirling, who also arranged for him to visit Scotland in 1848. Through most of his life, Chopin suffered from poor health. He died in Paris in 1849, at the age of 39, probably of tuberculosis. | | | | | | | | | | | | | | | |  |
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|  | **Guidance notes for completion of TB cohort review presentation form** | | | | | | | | | | | | | | | |  |
|  | * This is an electronic form for completion by case managers. * Using an electronic form allows us to instantly analyse the data returned to us. This form should work with any version of Microsoft Word from version 2003 onwards. If you have a very old (>10 years) version of Word and are unable to complete the form, please let us know. * To enter data, simply enter your information in the areas marked in the grey areas. * You can enter four types of data: dates, numbers, free text, a selection from a drop down list, or a tick in a box. If you are not sure what to enter at any point, click on the grey area and press the F1 key – a box will pop up with a reminder. * You can use the mouse to move between questions. You can also use the Tab and arrow keys. * Arrows indicate linked questions. If you have answered one question a particular way, you may need to provide additional information, and this will be indicated by an arrow. * Once you have entered your data, save the form as you would normally save a Word file (tip: Ctrl-S, followed by Alt-F4 is a useful shortcut). * Please, as far as you are able, complete the electronic form and return it securely to the cohort coordinator, by the deadline given. * Please make sure to order case notes well in advance to allow enough time for completing the form. * Please advise the cohort coordinator as soon as possible of any likely problems with returning completed forms in time. * If there is any information you wish to record but cannot find a suitable place for, please record it in the additional notes section. * Some fields should already be completed with ETS case data to minimise the amount of information to be collected. If you notice that any of this information is incorrect, then please inform one of the HPA representatives at the review. * All forms should be stored securely with due regard for patient confidentiality, using an encrypted USB disk to bring the forms to the cohort review. * Forms should not be sent by unencrypted email or left on non-NHS computers after use. * Forms should only be sent (i) from nhs.net account to nhs.net account, (ii) by another form of encrypted email or (iii) in a directly encrypted format (using software such as [dscrypt](http://www.softpedia.com/get/Security/Encrypting/dsCrypt.shtml)). * Key definitions used in the form:   + “Enhanced case management” (ECM) commences from suspicion of disease and includes directly observed treatment (DOT) in conjunction with a package of supportive care tailored to patients' needs and should be available to patients in both high and low incidence areas. All socially and/or clinically complex TB patients must be able to access ECM and should be referred to specialist centres where necessary.   + “Hard-to-reach” groups at risk of TB include children, young people and adults whose social circumstances or lifestyle, or those of their parents or carers, make it difficult to:     - recognise the clinical onset of tuberculosis     - access diagnostic and treatment services     - self-administer treatment (or, in the case of children and young people, have treatment administered by a parent or carer)     - attend regular appointments for clinical follow-up.   + For contact screening purposes, a child is defined as a person aged less than 16 years of age. | | | | | | | | | | | | | | | |  |
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