CRF 11- ACTIVE TB INITIAL EVALUATION FORM

A1.Participant's ID number C C C - C C C C **A2. Center** _____

TB0. Research Staff completing the form _____

TO BE COMPLETED WITHIN 24 HRS OF SUSPECTED TB

ACTIVE TB INITIAL EVALUATION

TB1. Date C C C C C C C C C
D D M M M Y Y Y Y

TB2. Is the study participant suspected to have active TB? c Yes c No

CONTINUE ONLY IF STUDY SUBJECT IS SUSPECTED TO HAVE ACTIVE TB