Appendix (3)
Data collection forms-1
REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME

CHEST SYMTOMETIC FORM

)RM NO. <idnum>
LLEGE _____
IC _____
\LUKA _____
STRICT _____
\ME _____ Pt. PRESENT DURING VISIT ___
;E ## IF YES, THEN INTERVIEWED ___
;X _____
)UCATIONAL _____
:CUPATION _____
COME PER MONTH Rs. #####
'PE OF HOUSE _____
IOKING HABIT ___
.COHOL ___
\RE YOU SUFFERING WITH {COUGH} WITH EXPETORRETION ___
F YES,THEN WHAT WAS THE {DURETION} IN WEEKS ###
(IF DURETION IS LESS THEN 3 WEEKS STOP THE INTERVIEW)
VHAT ARE THE OTHER SYMTOMS YOU HAVE? PLEASE GIVE DURETION.
FEVER ___ IF YAS, THEN {FEVER-DURETION} IN WEEKS ###
Wt. Loss ___ IY YES, THEN {Wt LOSS DURETION} IN WEEKS ###
{APETITE REDUECED} ___IF YES, THEN APETITE DURETION IN WEEKS ###
{HAEMOPTYSIS} ___ IF YES,THEN {HAEMDURERTION} IN WEEKS ###
IF{ANY OTHER} SPECIFY _____{OTHER DURETION} ###
)O YOU THINK THAT YOUR COUGH NEEDS {MEDICAL ATTENTION}? ___
(IF NO THEN ASKS Q.11 DIRECTLY)
[AVE YOU TAKEN TREATMENT FOR COUGH? _____
F YES, THEN PLEASE GIVE THE PLACE OF TREATMENT_____
/HAT TREATMENT YOU HAD TEKEN? PLEASE CONFORM FROM MEDICAL
ESCRIPTION.
INJECTION ___
ANTIBIOTICS ___
COUGH MIXTURE ___
TONIC ___
IV DRIP ___
ANY OTHER TREATMENT IF YES PLEASE SPECIFIES. _____
'HETHER ANY {INVESTIGATION} IS DONE BY TREATING DOCTOR? ___
IF YES, THEN SPECIF
X RAYS CHEST ___
SPUTOM AFB ___
BLOOD TC DC ___
ESR ___
URINE EXAM ___
TUBERCULIN TEST___
OTHER INVESTIGATION _____
X-RAYS CHEST TAKEN THEN WHETHER IT IS TAKEN AFTER SPUTOM AFB ____

Appendix

10 WHAT WAS THE EXPENDITURE MADE BY YOU? PLEASE GIVE DETAIL. ____

DOCTOR FEE Rs.	#####
DRUGS CAST Rs.	#####
INVESTIGATION FEE Rs.	#####
TRAVELLING Rs.	#####
OTHER EXPENCES Rs.	#####
TOTAL Rs.	######

11 How can one recognize a person suffering from lung Tuberculosis?

(a) Cough ___
(b) Weakness ___
(c) Loss of Appetite ___
(d) Blood in sputum ___
(e) Short of breathe ___
(f) Fever ___
(g) Chest Pain ___
(h) No Response ___
(i) Other Specify _____

12 If no response for Q.11 then asked "If a person has productive cough, fever, and blood in sputum, WHAT COULD HE BE SUFFERING FROM? _____

13 Please tell us weather you have been told or informed about the following details of T.B. and if so, from whom/where source did you get this information. (For source of information please tick under relevant code as per following Details Code: Doctor (Dr), Health worker (HW), Relative and friends (Rf), Other Patient (Pt), Village elder (VE), Mass media T.V.radio (MM)).

	Knowledge	Awareness	Source
(a) One can get TB from another Person who has TB.	<Y>	DR<Y> HW<Y> RF<Y> Pt<Y> VE<Y>	MM <Y>
(b) A germ of TB can be seen in Sputum of patient through microscope.	<Y>	DR<Y> HW<Y> RF<Y> Pt<Y> VE<Y>	MM <Y>
(c) A TB patient (who is not taking treatment) cough or sneezed then he can spread the disease.	<Y>	DR<Y> HW<Y> RF<Y> Pt<Y> VE<Y>	MM <Y>
(d) Taking all medicine regularly is very critical to prevent the spread of disease.	<Y>	DR<Y> HW<Y> RF<Y> Pt<Y> VE<Y>	MM <Y>
(e) TB is 100% curable	<Y>	DR<Y> HW<Y> RF<Y> Pt<Y> VE<Y>	MM <Y>
(f) TB drugs are available free of cost at all Govt. Hospital .	<Y>	DR<Y> HW<Y> RF<Y> Pt<Y> VE<Y>	MM <Y>
(g) Is there any vaccine for TB?	<Y>	DR<Y> HW<Y> RF<Y> Pt<Y> VE<Y>	MM <Y>

14 Do you know about the institution where the facility for diagnosis and treatment of TB available in your district.

(a) PHC <Y>
(b) CHC <Y>
(c) GH <Y>
(d) NGO <Y>
(e) Private <Y>
(f) DTC <Y>
(h) DONOT KNOW <Y>

15 Is there any institution nearer to your house where the diagnosis and Treatment for TB is available free of cost <Y>
If Yes, Specify the name

(a) PHC <Y>
(b) CHC <Y>
(c) DTC <Y>
(d) NGO <Y>
(e) Private Hospital <Y>
(f) Other specify _____

16 Weather the facility of diagnosis and treatment is available at PHC/CHC located near to your house.

(a) Diagnosis <Y>
(b) Treatment <Y>

17 Weather you {know health worker} who is coming from PHC. <Y>

18 If Yes, Had the health {worker visited} at your house <Y>

19 If Yes, Then how many time he visited your house during one month ##

20 What was the purpose of his visit?

(A){Malaria} <Y>
(B){Vaccination} <Y>
(C){MCH} <Y>
(d) {TB} <Y>
(E){Family planning} <Y>
(f) Other, specify _____
(G){Do not know} <Y>

21 Do you know that Health Worker can help you?
for diagnosis and treatment of TB <Y>

22 How did you disposed off your sputum?

(A) Spitted in street <Y>
(b) Collected and Burnt <Y>
(C) Buried in the ground <Y>
(d) Thrown into lavatory <Y>
(e) Other, Specify _____

23 Are you ready to give your sputum for Exam? <Y>
If No, then why? ({Reason}): _____

24 If Yes, Then sputum result Exam. (Fill from lab Result):

	Smear No. ###	Result.
(A){First Spot} sample		___ {GRADING F} ___
(B){Second} over {night}		___ {GRADING S} ___
(C){Third spot}		___ {GRADING T} ___

25 WHETHER SPUTOM SAMPLE GIVEN FOR CULTURE AND SENSITIVITY ___

26 Result of culture Examination of over night sample
Culture No. ### Result. ___

27 Result of drug {sensitivity}
(A){INH} _____
(B){ETM} _____
(C){RMP} _____
(D){SM} _____

Appendix

Data collection form 2

REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME

Tuberculosis Patient Form

FORM No. <idnum>
Village _____
Primary Health Centre {P.H.C.} _____
Taluka _____
District _____
Name of Patient _____
Pt. PRESENT AT THE TIME OF VISIT <Y>
IF YES, THEN INTERVIEWED <Y>
If no, then what was the reason? _____
Age ##
Sex _____

1 Could you tell us, what is the problem for which you have been asked to take treatment? _____
If no response (1) than ask Q. (2)
2 Is the problem you have {tuberculosis}? _____
3 What are the symptoms you had at the time of diagnosis?
(A) Cough <Y>
(b) Weakness <Y>
(c) Loss of appetite <Y>
(d) Blood in sputum <Y>
(e) Short breathe <Y>
(f) Fever <Y>
(g) Chest pain <Y>
(h) Other, specify _____
4 Initially when you developed symptoms, to whom you had first contacted? _____
5 Who suspect that you are suffering from tuberculosis?_____
6 What is the investigation made at the time of diagnosis?
X-ray chest <Y>
Sputum <Y>
E.S.R. <Y>
Other specify _____
7 If sputum was examined then how many time. #
8 When you ask to give sputum specimen for examination, how did you produce it? _____
9 What are the regimen pt. have taken? _____
IF OTHER REGIMEN THEN SPECIFY _____
10 How you got drugs? _____
11 If you are getting drugs form Health workers at your house/Place of work, Please tell us the following.
(A) How regularly you are taking drugs _____
(b) Do you take drugs in presence of some one? ___
If yes then in whom presence? _____
(c) What is the frequency of taking drugs? _____
12 Do you buy drugs from shop? _____
If yes then how much money you spent to buy drugs per month #####

13 Is there any side effect of drugs that you had noticed? ___
If yes then what was that side effect MAJOR _____
side effect MINOR _____
14 Were you admitted to any hospital for your disease? ___
If Yes, Name of the hospital _____
Duration of stay in days. ###
15 Was there any default in taking the treatment? ___
If yes, then (a) duration in days ###
(b) Reason for interruption _____
16 Weather any body from government visit you during treatment default ___
If yes, who visited? _____
If not, then had you received any reminder letter ___
17 How long you need treatment for your disease? _____
18 Can you tell me the duration of the treatment?
Advise by the treating doctor (in month) ##
19 Recently any of your family member suffered with minor illness ___
If yes, had he taken treatment ___
If yes, then please name the place of treatment? _____
20 Any of your near relatives currently suffering from tuberculosis? _____
21 How can one recognize a person suffering from lung tuberculosis?

Cough	<Y>
Weakness	<Y>
Loss of appetite	<Y>
Blood in sputum	<Y>
Short of breathe	<Y>
Low grade fever	<Y>
Chest pain	<Y>
Other, Specify	_____

22 What is the cause of T.B.? _____
23 Can TB spread from one person to another <Y>
If yes, then how does it spread? _____
24 How do you dispose your sputum? _____
25 Can you name the institution, where the facility for the diagnosis and treatment of tuberculosis is available in your district?

PHC	<Y>
CHC	<Y>
NGO	<Y>
GH	<Y>
OTHER	_____

26 Is there any institution, which is available nearer to your house, where the Diagnosis and treatment of tuberculosis is available free of cost? <Y>
If Yes, Please specify _____

28 Weather the facility of diagnosis and treatment is available at primary health centre nearer to your house?
Diagnosis _____
Treatment _____
29 Are you satisfy about the services of government hospital _____

30 Your occupation _____
31 Your education _____
32 Your monthly income #####
33 Number of member in your family ##
34 Number of rooms in your house #
35 Your monthly family income Rs. #####
36 Any comment/observation relevant to the study, made by the patient
1 _____
2 _____
3 _____
37 Do you have sputum now a day? ___
If yes, are you ready to give sputum for examination? ___
If yes, then smear No. ###
First spot sample ___
Second overnight sample ___
Third spot sample ___

38 Sputum smear A.F.B. culture examination ___
IF YES THEN, CULTURE No. ### RESULT. ___
39 Sputum A.F.B. Drugs sensitivity
Streptomycin _____
Isoniazid _____
Ethambutol _____
Rifampicin _____

Appendix

Data collection form - 3
National Tuberculosis Control Programme Tuberculosis
Death Form

FORM No.	<idnum>
Village:	_____
PHC:	_____
District:	_____
Name of diseased	_____
Date of death	<dd/mm/yy>
Age at death:	Year ## M##
Relation of informant	_____
Sex	_____

(1) The person who died was suffering from which disease? _____
(2) Time laps between first time diagnosis and death YEAR ## MONTHS ###DAYS ##
(3) Place of treatment: _____
(4) If the pt. was suffering from T.B. then,
What was the treatment regimen received by pt. _____
(5) Duration of treatment in months ##
(6) What was the regularity of treatment? _____
(7) Weather hospitalized during the treatment <Y>
If yes, Name the hospital _____
Duration of stay (in days) ###
Reason for admission _____
(8) Place of death: _____
(9) Cause of death: _____
(15) Any other associated disease: _____

Appendix

Data collection form-4

REVISED NATIONAL TB CONTROL PROGRAMME
MEDICAL OFFICER FORM

FORM No. <idnum>
DATE OF FILLING FORM <dd/mm/yyyy>
NAME OF INSTITUTION _____
PLACE OF INSTITUTION _____
TALUKA _____
DISTRICT _____
DATE OF INTERVIEW <dd/mm/yyyy>

Q.1 FROM HOW MANY {YEARS} YOU ARE WORKING WITH HEALTH SERVICES? _____

Q.2 PLEASE GIVE PRIORITY No. TO FOLLOWING NATIONAL HEALTH PROGRAMME AS PER YOUR OWN PRIORITY.

HEALTH PROGRAMME	PRIORITY
FP	##
MALERIA	##
TB	##
CSSM	##
UIP	##
SCHOOL HEALTH	##
LEPROSY	##
POLIO ERADICATION	##
ICDS	##
OTHER	##
PLEASE SPECIFY	_____

Q.3 HAVE YOU TAKEN TRAINING FOR TB CONTROL PROGRAMME ___
Q.4 IF YES, THEN YEAR OF TRAINING ####
PERIOD OF TRAINING IN DAYS ##
TRAINING INSTITUTE _____
PLACE OF TRAINING _____
Q.5 ARE YOU HAVING TB CONTROL PROGRAMME {MODULES}? ___
Q.6 HOW MANY NEW PT. ATTENDED TO YOUR OPD DURING LAST MONTH?#
WHAT IS THE No.OF CHEST SYMPTOMATIC ATTENDED 2.5%OF NEW OPD #
Q.7 HOW MANY CHEST SYMTPTOMATIC Pt.EXAMINED FOR SPUTUM AFB? ___
CHEST SYMPTOMATIC EXAM.AS PER 2.5% OF NEW OPD _____
Q.8 PLEASE GIVE NAME OF INSTITUTION WHERE FACILITY FOR DIANOSIS AND TREAMENT OF TB IS AVAILABLE NEAREST TO YOU?

1 _____
2 _____
3 _____

Q.9 PLEASE GIVE THE DETAILS ABOUT SUPERVISORY VISIT MADE TO YOUR INSTITUTION DURING CURRENT YEAR.

STATE OFFICER VISITED___IF YES, THEN DATE OF LAST VISIT____
CDHO VISITED ___ IF YES, THEN DATE OF LAST VISIT____
MO TB UNIT VISITED ___ IF YES, THEN DATE OF LAST VISIT____
STS VISITED ___ IF YES, THEN DATE OF LAST VISIT____
STLS VISITED ___ IF YES, THEN DATE OF LAST VISIT____
TBS VISITED ___ IF YES, THEN DATE OF LAST VISIT____
OTHER VISITED ___ IF YES, THEN DATE OF LAST VISIT____
IF OTHER PLEASE SPECIFY _____

Q.10 WHO VISITED YOUR SUB-CENTRE LOCATED TO REMOTE AREA DURING LAST 3 MONTHS

CDHO ___
DTO ___
MO TC ___
MO ___
STS ___
MPHS/FHS ___
TBS ___

Q.11 WHO PREPARE MONTHLY REPORT OF TB CONTROL AT YOUR CENTRE? ____

Q.12 ARE YOU RECIEVED FEED BACK OF REPORTS ___

Q.13 KNOWLEDGE ABOUT NATIONAL TB REGIMEN?

RA IP _____IF RESPONDED _____
RA CP _____ IF RESPONDED _____
RB IP _____IF RESPONDED _____
RB CP _____ IF RESPONDED _____
R1 IP _____IF RESPONDED _____
R1 CP _____ IF RESPONDED _____
R2 IP _____IF RESPONDED _____
R2 CP _____ IF RESPONDED _____
CAT.1 IP _____IF RESPONDED _____
CAT.1 CP _____ IF RESPONDED _____
CAT.2 IP _____IF RESPONDED _____
CAT.2 CP _____ IF RESPONDED _____
CAT.3 IP _____IF RESPONDED _____
CAT.3 CP _____ IF RESPONDED _____

Q.14 PLEASE GIVE YOUR OWN REGIMEN FOR FOLLOWING CONDITION.

NEW SPUTUM POSITIVE _____
X-RAYS POSITIVE SPUTUM NEGATIVE _____
SERIOUSLY ELL EXTRA-PULMONARY TB _____
EXTRA PULMONARY TB _____

Q.15 CURRENTLY HOW MANY No.TB Pt. ARE UNDER TREATMENT AT YOUR CENTRE ###

Q.16 HOW MANY Pt. ARE DEFAULTED DURING LAST 3 MONTHS ____
AWARENESS ABOUT THE DEFAULT TB PATIENTS ___

Q.17 WHO VISIT THE DEFAULT TB Pt. AT YOUR CENRE?

MO ___
MPHS ___
.FHS ___
STS ___
TBS ___
DOT WORKER ___
OTHER ___ PLEASE SPECIFY _____

Q.18 ARE YOU GETTING SUFFICIENT AKT DRUGS FROM DTC/TB UNIT? _____

Q.19 YOUR SUGGESTION FOR BETTER IMPLIMENTATION OF TB CONTROLS.

1 _____
2 _____
3 _____
4 _____
5 _____

NAME OF MEDICAL PERSONNEL _____
DESIGNATION _____
DATE <dd/mm/yyyy>
PLACE _____

Appendix

Data collection form – 5

REVISED NATIONAL TB CONTROL PROGRAMME
PARA-MEDICAL FORM

FORM NO. <idnum> DATE OF FILLING OF FORM <dd/mm/yyyy>
NAME OF INSTITUTION _____
DISTRICT _____

Q.1 HOW LONG YOU ARE WORKING WITH HEALTH SERVICES? _____
Q.2 AWARENESS OF CURRENT NATIONAL TB CONTROL PROGRAMME ____
Q.3 PRIORITY OF NATIONAL HEALTH PROGRAMME
AS PER HEALTH PERSONNEL?
FIRST PRIORITY _____
SECOND PRIORITY _____
THIRD PRIORITY _____
Q.4 HAVE YOU TAKEN TB PROGRAMME TRAINING
DURING LAST 5 YEARS? ___
Q.5 IF YES, THEN PLEASE GIVE DETAILS,
YEAR OF TRAINING ####
DURATION OF TRAINING IN DAYS ##
PLACE OF TRAINING _____
TRAINING AUTHORITY _____
Q.6 AWARENESS OF BCG VACCINE PRESENT? ___

(BCG KNOWLEDGE (ASK Q-7 TO Q-13 TO HEALTH WORKER ONLY)
Q.7 HAVE YOU TAKEN {BCG TRAINING}? ___

Q.8 IF YES, THEN PLEASE GIVE DETAILS OF TRAINING,
YEAR OF TRAINING ####
DURATION OF TRAINING IN DAYS ##
TRAINING AUTHORITY _____
PLACE OF TRAINING _____
Q.9 BCG GIVEN AT WHAT AGE? _____
Q.10 BCG GIVEN AT WHICH PART OF BODY? _____
Q.11 WHETHER BCG GIVEN IN YOUR AREA OR NOT? ___
Q.12 IF YES, THEN WHO GIVE THE BCG IN YOUR AREA? _____
Q.13 PLEASE GIVE THE NO.CHILD
WHO WERE BCG VACCINETED DURING LAST 3 MONTHS ####
Q.14 WHEN YOU SUSPECT TB? PLEASE GIVE 4 SYMPTOMS.
COUGH WITH EXPECTORATION MORE THEN 3 WEEKS ___
LOSS OF APPETITE ___
LOSS OF WEIGHT ___
LOW GRAD FIVER ___
BLOOD IN SPUTUM ___
PAIN IN CHEST ___
OTHER ___
IF YES, THEN PLEASE SPECIFY _____
Q.15 PLEASE GIVE THE BEST METHODS OF DIAGNOSIS _____

Q.16 NO. OF SPUTUM EXAM. FOR DIAGNOSIS _____
Q.17 NO. OF SPUTUM EXAM. FOR FOLLOW-UP _____
Q.18 NO.OF TB PT. UNDER TREATMENT IN YOUR WORKING AREA? ____
Q.19 WHO GIVE DOTS TREATMENT TO TB PT. IN YOUR WORKING AREA?

GP ___
NGO ___
PHARMACIST ___
HEALTH WORKER ___
OTHER ___
IF OTHER, PLEASE SPECIFY _____
ICDS WORKER ___
ICDS HELPER ___
DAI ___
CHV ___
OLD TB PATIENT ___

Q.20 HAVE YOU REFFERED CHEST SYMPTOMATIC FROM YOUR WORKING AREA? ___
Q.21 IF, YES THEN WHERE YOU HAVE REFFERED _____
Q.22 PLEASE GIVE THE NAME OF INSTITUTION WHERE FACILITY FOR DIAGNOSIS AND TREATMENT IS AVAILBLE NEAREST TO YOUR WORKING AREA?

DIAGNOSIS _____
TREATMENT _____

Q 23 WHAT IS DOTS, PLEASE EXPLAIN? _____
Q.24 HOW MANY DOSE ARE GIVEN WEEKY IN RNTCP REGIMEN? _____
Q.25 PLEASE GIVE THE DURETION OF TREATMENT FOR FOLLOWING DRUGS REGIMEN?
CAT-1 _____, IF RESPONDED THEN {DURETION} IN MONTHS ##
CAT-2 _____, IF RESPONDED THEN {DURETION} IN MONTHS ##
CAT-3 _____, IF RESPONDED THEN {DURETION} IN MONTHS ##
Q.26 PLEASE GIVE THE NAME OF OFFICER, WHO VISITED YOUR SUB-CENRE DURING LAST 3 MONTHS?

NO BODY ___
STS ___
MPHS ___
FHS/HV ___
TBS ___
MO ___
DTO ___
CDHO ___
OTHER ___
IF OTHER THEN SPECIFY _____

Q.27 IF YES, THEN ANY BODY VISITED THE PT. HOUSE DURING LAST 3 MONTHS? ___
Q.28 IF NO, THEN WHEN THE LAST SUPERVISORY VISIT MADE TO YOUR SUBCENRE? _____
Q.29 IS THERE ANY TB {PT. DEFAULTED} ON TREATMENT DURING LAST ONE YEAR? ___
Q.30 IF YES, THEN WHAT WAS THE {REASON}? _____
Q.31 HAVE YOU RECIEVED THE TRAINING {MODULES}? ___

Q.32 PLEASE GIVE YOUR SUGGESTION TO EFFECTIVE IMPLEMENTATION OF TB CONTROL PROGRAMME IN YOUR AREA?

1 _____
2 _____
3 _____
4 _____
5 _____

NAME _____
DESIGNETION _____
PLACE _____
DATE <dd/mm/yyyy>□

Appendix

Data collection form-6

REVISED NATIONAL TB CONTROL PROGRAMME
ANALYSIS OF TB CARDS

FORN NO. <idnum>
NAME _____
TREAMENT CARD AVAILABLE FOR ANALYSIS ___
HEALTH UNIT _____
DISTRICT _____
TYPE OF DISTRICT _____
REGISTRATION NUMBER _____
AGE ##
SEX _____
ADDRESS _____
AREA OF RESIDENCE _____
CONTACT PERSON _____
DOT WORKER _____
DISEASE CLASSIFICATION _____
IF PULMONARY _____
IF EXTRA PULMONARY SPECIFY SITE_____
TYPE OF PATIENTS _____ IF OTHER SPECIFY _____
PLACE OF DIAGNOSIS _____
PLACE OF TREATNEMT _____
REGIMEN _____ IF OTHER REGIMEN SPECIFY _____
INITIAL EXAMINATION
SPUTUM _____IF SPUTUM DONE THEN RESULT _____
X-RAYS _____IF X-RAYS DONE THEN RESULT _____
X-RAYS DONE THEN WEATHER IT IS AFTER SPUTUM EXAM. ___
OTHER INVESTIGATION ___IF YES SPECIFY _____
SPUTUM FOLLOW-UP
FIRST FOLLOW-UP _____IF DONE THEN {RESULT 1F} _____
SECOND FOLLOW-UP _____ IF DONE THEN {RESULT2F} _____
THIRD FOLLOW-UP _____IF DONE THEN {RESULT3F} _____

WIEGHT OF PATIENTS
INITIAL WT. ##KG
END OF IP WT. ##KG
CP 2 MONTH WT. ##KG
END OF TREATMENT ##KG
INTENSIVE PHASE
No IP VISIT DUE ##
No IP VISIT DONE IN TIME ##
No IP VISIT DONE LATE BY-
IP LATE BY 1-3 DAYS ##
IP LATE BY 4-7 DAYS ##
IP LATE BY 8-15 DAYS ##
IP LATE BY 16-30 DAYS ##
IP LATE BY 31-60 DAYS ##
IP LATE BY 61-ABOVE DAYS ##
IP TOTAL LATE VISIT ##

I.P.EXTENDED BY ONE MONTH _____
CONTINUATION PHASE
No CP VISIT DUE ##
No CP VISIT DONE IN TIME ##
No CP VISIT DONE LATE BY-
CP LATE BY 1-3 DAYS ##
CP LATE BY 4-7 DAYS ##
CP LATE BY 8-15 DAYS ##
CP LATE BY 16-30 DAYS ##
CP LATE BY 31-60 DAYS ##
CP LATE BY 61-ABOVE DAYS ##
CP TOTAL LATE VISIT ##
No. OF DEFAULT OCCASIONS ##
No. OF DEFAULT OCCASIONS WHERE DEFAULT FIRST ACTION DUE ##
No. OF DEFAULT OCCASIONS WHERE DEFAULT FIRST ACTION DUE AND TAKEN ##
IF DEFAULT ACTION TAKEN THEN TYPE OF FIRST ACTION TAKEN _____
IF HOME VISIT DONE THEN WHO VISITED
DOT WORKER ___
MPHS ___
FHS/HV ___
STS ___
MO PHC ___
MO TC ___
DTO ___
OTHER ___ IF YES SPECIFY _____
No. OF DEFAULT OCCASIONS WHERE DEFAULT SECOND ACTION DUE ##
No. OF DEFAULT OCCASIONS WHERE DEFAULT SECOND ACTION DUE AND TAKEN ##
IF DEFAULT ACTION TAKEN THEN TYPE OF SECOND ACTION TAKEN _____
IF HOME VISIT DONE THEN WHO VISITED
DOT WORKER ___
MPHS ___
FHS/HV ___
STS ___
MO PHC ___
MO TC ___
DTO ___
OTHER ___ IF YES SPECIFY _____
TREATMENT OUT COME _____
REASON OF STOP TREATMENT _____
ANY SPECIAL COMMENT IF SEEN _____
_____
_____
_____