

Risk Assessment and Needs Assessment
 Nikshay Id _____ DMC Name: _____

Date: _____
 TU Name: _____

Facility Name _____

PRAD Id: _____

Name:.....		Age:Yrs DOB: DD/MM/YYYY	
Current Address.....		Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> TG	
.....		Religion: <input type="checkbox"/> Hindu <input type="checkbox"/> Muslim	
.....		<input type="checkbox"/> Christian <input type="checkbox"/> Other	
Land Mark:.....		Education: <input type="checkbox"/> Cannot	
permanent Address		Read/Write <input type="checkbox"/> <5 std <input type="checkbox"/> 5-10 std. <input type="checkbox"/>	
.....		12 th <input type="checkbox"/> Diploma <input type="checkbox"/> Graduate <input type="checkbox"/>	
.....		Post Graduate	
Contact No		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	
		<input type="checkbox"/> Widowed <input type="checkbox"/> separated/divorced	
Alternate No		Occupation:	

Type of TB: Pulmonary Extra Pulmonary

History of TB treatment: Never treated or treatment <1 month Previously treated for TB

Anti TB medication from: Private sector Public sector

Treatment Regimen Initiated: DS TB DRTB

Date of treatment initiation: DD/MM/YYYY

Risk assessment

Risk factor	Assess if present (Y/N)	Action Taken (Y/N)	Details of Action taken
About TB			
Does patient understand TB disease and/or treatment? <i>Do you know what disease you have? what did the health worker say to you?</i> <i>How does TB spread? By air / Droplet</i> <i>What is the common symptom of TB? Cough</i> <i>What is the test for lung TB? Sputum test</i> <i>Is TB Curable? Yes TB is curable</i>			
Acceptance of TB disease and/or treatment <i>Does the patient accept that s/he has TB?</i> <i>Is the patient ready to take treatment for long term (At least 6 months)?</i> <i>Is the patient willing to take tablets and / or injection as prescribed?</i>			
About Person			
Regular travel/ likely migration			
Co-existing conditions (write codes) <i>a. HIV b. DM c. Silicosis d. Undernutrition e. Pregnancy f. Breast feeding G. Other Specify</i>			
Alcoholism			
Tobacco Addiction			

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Have you ever experienced discrimination or denial of rights because of TB?			
About family			
Living Alone / No Care Giver			
Do you have the support of family members?			
Is there some body who knows about your TB status who can support you in treatment?			
Did you face any crisis recently in the family or any plan of social event in near future?			
Financial difficulties			
About treatment			
Problem with access to drugs			
Were you irregular to treatment previously?			
Symptoms persisting			

Social security needs Assessment

Social entitlements	Specify Details	Have this? Y/N/NA	Need support for availing this? Y/N	If linked through program, date of linkage
	Aadhar Card			
	Bank Account			
	Ration Card (APL/ BPL)			
	DBT linkage			
	Link to free TB medicines			
Nutrition support	Anthyodaya			
	ICDS			
	Others			
Livelihood support	Income generation activity			
	Pension schemes			
Health related schemes (Health Insurance etc)	Janani Suraksha Yojana (JSY)			
	Rashtriya Swasthya Bima Yojana(RSBY)			
	Other state related health schemes			
	Other Health Insurance Schemes			
Any other schemes				

Patients preferred mode of care and support		
<input type="checkbox"/> In Person <input type="checkbox"/> THALI <input type="checkbox"/> RNTCP <input type="checkbox"/> JEET <input type="checkbox"/> Support Group	<input type="checkbox"/> TB Careline <input type="checkbox"/> Technology based support (99 DOTS, Merm Etc). <input type="checkbox"/> Call centre	<input type="checkbox"/> Facility / provider Support <input type="checkbox"/> Self-monitored/ Family supported only <input type="checkbox"/> Other (Specify)
Iagree to this option/s for follow up		Signature of the patient:

Risk and Needs Assessment done by

Project: THALI JEET RNTCP

Name: _____

Designation:

staff Id:.....