The United Republic of Tanzania

Ministry of Health

NATIONAL TB AND LEPROSY PROGRAMME

DR-TB Treatment Card

DR-TB Registration Number: _____

2023 Edition

Ministry of Health

DR-TB Registration Number _____

Name: _____

Sex: _____

Age: _____

Date of DR-TB registration: ____ / ____ / _____

District TB registration number: _____

Date of district TB registration: ____ / ____ / _____

Patient Address: _____

Telephone number: _____

Name of (next of kin): _____

Telephone (Next of kin): _____

District: _____ **Region:** _____

Treatment Centre: _____

Site (mark one):	PTB	EPTB	Both
If EPTB, describe site:			

NATIONAL TB AND LEPROSY PROGRAMME

DR-TB Treatment Card

	Registration group	Select 1 only
1	New	
2	Relapse	
3	After Lost to follow-up	
4	After failure of first line drugs	
5	Transfer in (from another 2nd-line treatment center	
6	Other	

Previous tuberculosis treatment episodes

No.	Start date (if unknown, put year)	Regimen (write regimen in drug abbreviations)	Outcome

Used second- line drugs previously? ☐ Yes ☐ No

If yes, specify: _____

_____

Drug abbreviations:

H= Isoniazid
R= Rifampicin
E= Ethambutol
Z= Pyrazinamide
S= Streptomycin
H^{HD}= High Dose Isoniazid
Am= Amikacin
Lfx= Levofloxacin
Mfx= Moxifloxacin
Pto= Prothionamide
PAS=Paraminosalycylic acid
Bdq=Bedaquiline
Dlm= Delamanid
Cs= Cycloserine
Cfz = Clofazimine
Lzd= Linezolid
Eto= Ethionamide
Pa= Pretomanid

HIV Information (Fill for all patients)
HIV status: ☐ Y ☐ N ☐ Unknown
Date of test: ___/___/___ Results:
CD4 Cell Count: Date: ___/___/___
Viral load: : Date: ___/___/___
Started on ART: ☐ Y ☐ N Date: ___/___/___
Started on CPT: ☐ Y ☐ N Date: ___/___/___

ART = antitretroviral therapy;
CPT = co-trimoxazole preventive therapy

Antiretroviral Flow Sheet

Regimen	Start date	Stop date	Reason for stop/change

Weight & Nutrition Status Monitoring: Weight (+height for children) monthly; calculate BMI (kg/M^2) at baseline and every 6mo. for adults/ every 2 mo. for children

Month	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
Date																							
Weight																							
Height																							
Muac																							
BMI																							
BMI Clasification																							

KEY FOR BMI CLASSIFICATION
0. Normal 1. Severe Acute Malnutrition 2. Moderate Acute Malnutrition 3. Mildly under weight 4. Over weight 5. Obese

Medical or other conditions other than tuberculosis

Does the patient have any of the following conditions?		
Condition	YES / NO	Current Treatment (medication, frequency, dosage)
Hypertension	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Anemia	☐ Yes ☐ No	
Psychiatric disorder*	☐ Yes ☐ No	
Liver disease	☐ Yes ☐ No	
Renal insufficiency	☐ Yes ☐ No	
Cardiac disease	☐ Yes ☐ No	
Substance abuse	☐ Yes ☐ No	
Malnutrition	☐ Yes ☐ No	
Chronic lung disease	☐ Yes ☐ No	
Pregnancy	☐ Yes ☐ No	
Other (specify)	☐ Yes ☐ No	

* (e.g. depression, psychosis, suicidal intention, seizure s)

Any known allergies? ☐ Yes ☐ No

If yes, specify: _____

TB Contact Investigation

Date index case interview completed: ____/____/_____		
Date initial household assessment completed: ____/____/_____		
Summary of Contact Investigation	At index case diagnosis	At end of treatment
Number of contacts identified:		
Number of identified contacts that were screened:		
Number of symptomatic contacts with Xpert/Truenat results		
Number of contacts diagnosed with TB:		
Number of contacts presumptive/confirmed TB or RR TB		

Patient name:_____ DR TB Registration No. _____

Drug-susceptibility testing (DST) results (notation method for DST: R = resistant, S = susceptible, C = contaminated)

Date**	H	R	E	Z	S	Am	Lfx	Mfx	PAS	Eto	Cs	Bdq	Dlm	Lzd	Cfz	Pa	Types of test Truenat, Xpert, Xpert MTB/XDR, LPA, Phenotypic DST

NOTE: For date fields indicated with "**" in DST and Bacteriology tables, enter date specimen collected

Bacteriology - Prior*refers to specimen obtained before start of DR-TB treatment

Month	Date**	Specimen Number	Smear Result	Specimen Number	Culture Result##
Prior*					
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					

##Result= Negative, number colonies, +, ++, +++, NTM/MOTT, or contaminated

*** Colour vision enter N(Normal) and AN(Abnormal) for each eye

ECG Monitoring (if Bdq,Dlm, Cfz, Mfx)

Month	Date	QTcF Result*
Baseline		
2 Weeks		
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

*Calculate QTcF and record result (ms)

Vision Monitoring (monthly while taking Lzd or ethambutol)

Date	‡ Visual Acuity	‡ Color Vision
	L: R:	
	L: R:	
	L: R:	
	L: R:	
	L: R:	
	L: R:	
	L: R:	
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Date	Visual Acuity	Color Vision
	L: R:	
	L: R:	
	L: R:	
	L: R:	
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	L: R:	

** Visual acuity enter score for each eye (Between 6/6 to 6/60)

NOTE: If taking Bdq or Dlm, Ecg at baseline then week 2, 4, 8, 12 and 24 weeks of treatment.

Laboratory Monitoring

Date																					
ALT/SGPT																					
AST/SGOT																					
Creatinine																					
Cr Clearance																					
Potassium																					
Magnesium																					
Sodium																					
TSH																					
Uric acid																					
glucose																					
Lipase																					
Hemoglobin																					
WB count																					
Platelet count																					
CD4																					
viral load																					
Urine pregnancy test (UPT)																					

Chest x-ray* - Enter primary CXR findings

Date	Tick primary finding in addition to cavitary disease status if > 1 present	Other descriptive comments
At diagnosis	Cavitary disease? Yes☐ / No☐ ☐ Focal infiltrate/nodule(s) ☐ Lymphadenopathy only ☐ Pleural effusion ☐ Multi-focal infiltrates/nodules ☐ Fibrosis ☐ Miliary disease	
	☐ Improved ☐ Stable/unchanged ☐ Worsened	
	☐ Improved ☐ Stable/unchanged ☐ Worsened	
	☐ Improved ☐ Stable/unchanged ☐ Worsened	
End of treatment	☐ Improved ☐ Stable/unchanged ☐ Worsened	

*Note key findings of chest X-ray performed at diagnosis, during treatment, and at the end of treatment

DR-TB Treatment Regimen (date treatment started and dosage [mg], change of dosage, and cessation of drugs)

Date	H / H^{HD}	Z	E	S	Cs	Lfx	Mfx	Eto/Pto	Cfz	Bdq	Dlm	Lzd	Am	PAS	Pa	B6

Administration of drugs (one line per month)

Month	Day																													Total missed	%
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		

Mark in the boxes: X = Directly observed (in hospital or by DOT Nurse); → = (Draw a line) → Observed by treatment supporter; N = Not supervised; ∅= Medicine not taken

Patient name:_____ DR TB Registration No. _____

Adverse Event (AE)[#]

Date	Type (i.e. neuropathy, hepatitis, rash, etc.)	SAE?	Suspect drug	Intervention/Comments	Outcome	Date
		☐ Yes ☐ No			☐ Stable/unchanged ☐ Getting worse ☐ Recovered/resolved ☐ Died ☐ Getting better ☐ Unknown	
		☐ Yes ☐ No			☐ Stable/unchanged ☐ Getting worse ☐ Recovered/resolved ☐ Died ☐ Getting better ☐ Unknown	
		☐ Yes ☐ No			☐ Stable/unchanged ☐ Getting worse ☐ Recovered/resolved ☐ Died ☐ Getting better ☐ Unknown	
		☐ Yes ☐ No			☐ Stable/unchanged ☐ Getting worse ☐ Recovered/resolved ☐ Died ☐ Getting better ☐ Unknown	
		☐ Yes ☐ No			☐ Stable/unchanged ☐ Getting worse ☐ Recovered/resolved ☐ Died ☐ Getting better ☐ Unknown	
		☐ Yes ☐ No			☐ Stable/unchanged ☐ Getting worse ☐ Recovered/resolved ☐ Died ☐ Getting better ☐ Unknown	

[#] Document all AEs, management and outcomes, particularly those of special interest. AEs of special interest include: CNS toxicity (depression, psychosis) hypokalemia, optic nerve disorder, hepatotoxicity, hypothyroidism, lactic acidosis, pancreatitis, nephrotoxicity, prolonged QT interval, ototoxicity (hearing loss), myelosuppression and peripheral neuropathy. SAE=Serious adverse event defined as death, life-threatening, hospitalization required, prolonged, persistent or significant disability, incapacity, congenital anomaly, birth defect and otherwise medically important. If SAE, ensure aDSM report completed.

Treatment Review panel meetings: dates and decisions:

Date	Issue and Decision	Discharge Date	Next date

Contacts Tracing information:

S/No	Name of contacts	Relation to index	Screened (Tick √ appropriately)	Presumptive (Tick √ appropriately)	Confirmed TB or RR (Tick√ appropriately)

Date of Discharge from inpatient care to District level care: ____/____/_____

Comments:_____

_____

_____

_____

_____

Treatment Outcome:

Outcome	Mark one	Date
Cured		
Completed		
Died		
Failed		
Lost to follow up		
Not evaluated		

Name of treating clinician : _____ Signature: _____ Date: ___/ ___/ ___