DR-TB 06

THE UNITED REPUBLIC OF TANZANIA

Ministry of Health

National Tuberculosis and Leprosy Programme

DRUG RESISTANT TB MONTHLY TREATMENT FOLLOW-UP FORM

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First Name _____Middle Name _____Surname:_____
Age _____ (years) Sex ___ (M/F) DR-TB Reg. No. _____
Hospital File No.: _____ Facility _____ Council_____
Treatment Month._____

TB Symptoms (√) Where applicable

Improved	Not improved/ worsened
☐	☐ Cough
☐	☐ Bloody sputum (haemoptysis)
☐	☐ Fever/night sweats
☐	☐ Shortness of breath
☐	☐ Weight loss

Side Effects

- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Visual problems (recent change)
- ☐ Headache
- ☐ Confusion
- ☐ Rash
- ☐ Fatigue
- ☐ Ringing in ears
- ☐ Deafness
- ☐ Tingling in hands/legs/feet
- ☐ Jaundice (yellow eyes, skin)
- ☐ Joint pain
- ☐ Others _____
- ☐ None of the above

Adverse Events

- ☐ Hypokalemia
- ☐ Psychosis
- ☐ Depression
- ☐ Nephrotoxicity
- ☐ Ototoxicity
- ☐ Peripheral neuropathy
- ☐ Hypothyroidism
- ☐ Rash
- ☐ Hepatotoxicity
- ☐ Pancreatitis
- ☐ Lactic Acidosis
- ☐ Myelosuppression
- ☐ Prolonged QT Interval
- ☐ Optic Nerve Disorder
- ☐ Other _____
- ☐ No Adverse Events

Adherence Assessment

Any medication missed in the past month? ☐ YES ☐ NO

Type and doses of medication missed (to be identified by the health personnel) _____

_____

Reason for missing the above medications:

1. Side effects
2. Forgot
3. Alcohol abuse
4. Others _____

Has the patient visited the health facility daily during the past month? ☐ Yes ☐ No

If no, does the treatment supporter, supervise every daily dose? ☐ Yes ☐ No

Describe the relationship with the treatment supporter

Physical Exam

Wt _____ (kg)

Ht/Lng _____ (cm)

BP ___ / _____

Temp _____ (C)

Functional Status

☐ Functional

☐ Ambulatory

☐ Bedridden

☐ RR _____ /min

N	AN	
☐	☐	Head, ears, eyes, nose, throat _____
☐	☐	Lymph nodes _____
☐	☐	Heart _____
☐	☐	Lungs _____
☐	☐	Abdomen _____
☐	☐	Skin _____
☐	☐	Urogenital _____
☐	☐	Musculoskeletal _____
☐	☐	Neurological _____
☐	☐	Others _____

Lab results (blood tests, sputum smear /culture, etc.)

SPECIAL CONDITIONS

HIV Information (Fill for all patients)

HIV testing done: ☐ Y ☐ N ☐ Unknown

Date of test: ___/___/___ Results:

CD4 Cell Count: Date: ___/___/___

Started on ART: ☐ Y ☐ N Date: ___/___/___

Started on CPT: ☐ Y ☐ N Date: ___/___/___

Note details of condition in Comments section below

Pregnancy or breastfeeding	
Contraception	
Liver disorders	
Renal insufficiency	
Anemia	
Psychiatric disorders/ Epilepsy	
Diabetes mellitus	
Substance abuse	
Cardiac disease or Hypertension	
Other (specify)	

INVESTIGATIONS ORDERED THIS MONTH

Exam or Test	Date
☐ Sputum smear	____/____/____
☐ Sputum culture	____/____/____
☐ Chest X – ray	____/____/____
☐ Ecg	____/____/____
☐ Vision exam (acuity and color)	___/____/____
☐ DST (1st Line/2nd Line)	____/____/____
☐ RFT (serum creatinine)	____/____/____
☐ LFT (ASAT, ALAT, bilirubin)	____/____/____
☐ TSH	____/____/____
☐ FBP	____/____/____
☐ Serum electrolytes (potassium, magnesium, sodium)	____/____/____
☐ RBG	____/____/____
☐ Albumin	____/____/____
☐ HIV rapid tests	____/____/____
☐ CD 4 counts	____/____/____
☐ Viral load	____/____/____
☐ Other (specify test and date)	_____

OTHER COMMENTS: _____