THE UNITED REPUBLIC OF TANZANIA

Ministry of Health

National Tuberculosis and Leprosy Programme

DRUG RESISTANT TB MONTHLY TREATMENT FOLLOW-UP FORM

First Name ________________Middle Name _________________Surname:_______________
Age _______ (years) Sex ___ (M/F) DR-TB Reg. No. _________________________________
Hospital File No.: __________________ Facility _______________ Council_________________
Treatment Month._________________

TB Symptoms

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

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

Condition	
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 (one/two)	_____/_____/_____
☐ 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:____

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