

Form 9. IPT Register

Month & Year: _____

Date Evaluated (MM/DD/YY)	IPT No.	Name (SURNAME/ First Name/ Middle Name)	Age	Sex (M/ F)	Address & Contact Number	Exposure or Infection? (E/ I)	Date IPT Started (MM/DD/YY)	IPT Outcome (Indicate Date MM/DD/YY of Last Intake)					Remarks	
								Completed	Died	Failed	Lost to Follow-up	Not Evaluated		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)					(10)	



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Name of Facility:

Province/ City & Region:

Year:
