FORM 4A. TB NOTIFICATION FORM

Privacy Notice: It has been explained to me that all information collected in this form shall only be used for the purposes of clinical management, program management, and/or provision of psychosocial and financial support. If I have any query on or wish to revoke this authorization, I shall notify the facility head or contact ntp.helpdesk@doh.gov.ph or (02) 8230-9626. All information collected shall remain secured and confidential and only authorized personnel shall have access to them.

Patient's Signature over Printed Full Name

Reason of Notification: [ ] New/ Diagnosis [ ] Update/Start of Treatment *Please put an * or highlight on fields updated.* [ ] Final Outcome

Name of Facility:	NTP Facility Code:	Province/ HUC:	Region:

A. Patient Demographic

Patient's Full Name (SURNAME, Given Names, Name Extension, Middle Name):	Date of Birth (MM/DD/YYYY):	Age:	Sex (M/F):	Civil Status:
		YEARS MONTHS		

Permanent Address (House No., Street, Barangay, City/ Municipality, Province, Region & Zip Code):	Contact Number (include area code):	Nationality:
	PhilHealth No.:	

B. Laboratory Tests

Name of Test:	Xpert MTB/RIF [ ] Ultra	Smear Microscopy/TB LAMP	Chest X-ray	Tuberculin Skin Test	Other: ____
Date (MM/DD/YYYY):	Collection	Collection	Examination	Reading	
Result:					

C. Diagnosis

Diagnosis:	Date of Diagnosis (MM/DD/YYYY):	Date of Notification (MM/DD/YYYY):	Referred To (Name, Address, Facility Code, Province/HUC, Region):
[ ] TB Disease [ ] TB Infection			
	TB/ TPT Case Number:	Attending Physician:	

D. TB Disease Classification

Bacteriological Status:
[ ] Bacteriologically-confirmed TB [ ] Clinically-diagnosed TB

Anatomical Site:
[ ] Pulmonary [ ] Extra-pulmonary site: ____

Drug Resistance Bacteriological Status:
[ ] Drug-susceptible
[ ] Bacteriologically-confirmed RR-TB
[ ] Bacteriologically-confirmed MDR-TB
[ ] Bacteriologically-confirmed XDR-TB
[ ] Clinically-diagnosed MDR-TB
[ ] Other Drug-resistant TB ____

Registration Group:
[ ] New [ ] TAF
[ ] Relapse [ ] PTOU
[ ] TALF [ ] Unknown History

C. Diagnosis

Regimen Type at Start of Treatment:

[ ] Regimen 1 2HRZE/4HR
[ ] Regimen 2 2HRZE/10HR
[ ] Regimen 3 SSOR 4LfxBdq(6)CfzPtoEZHdH/5LfxCfzZE
[ ] Regimen 4 SLOR FQ-S 6LfxBdqLzdCfz/12LfxLzdCfz
[ ] Regimen 5 SLOR FQ-R 6LzdBdqDlmCfzCs
[ ] Regimen 6 __ Pedia MDR FQ-S
a LfxLzdCfzCs(Pas/Eto)
b LfxLzdCfzCs(Dlm/PAS)
c BdqLfxLzdCfz (Cs/Dlm)
[ ] Regimen 7__ Pedia MDR FQ-R
a LzdCfzCsPAS (Eto/Dlm)
b LzdCfzCsDlm (PAS/Eto)
c BdqLzdCfzCs (Dlm/PAS)
[ ] ITR (specify) ____
[ ] BPaL
[ ] 6H
[ ] 3HP
[ ] 3HR
[ ] 4R

Treatment Start Date (MM/DD/YYYY):

Regimen Type at End of Treatment:

F. Treatment Outcome

Regimen Type at Start of Treatment:

Outcome: [ ] Cured [ ] Failed [ ] Died
[ ] Treatment Completed [ ] Lost to Follow-up

Date of Outcome (MM/DD/YYYY):

Reason (if Failed, LTFU, or Died):