FORM 4B. DS-TB TREATMENT CARD

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

I. Case Finding/ Notification

Name of Diagnosing 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: YEARS MONTHS	Sex (M/F):	Civil Status:
Permanent Address (House No., Street, Barangay, City/ Municipality, Province, Region & Zip Code):		**Current Address** (House No., Street, Barangay, City/ Municipality, Province, Region & Zip Code):			
Contact Number (include area code):	**Other Contact Information:**	**PhilHealth No.:**	**Nationality:**		

B. Screening Information

Referred by (Name & Location):	Mode of Screening:	Date of Screening (MM/DD/YYYY):
[ ] public [ ] other public [ ] private [ ] community	[ ] PCF [ ] ACF [ ] ICF [ ] ECF	

C. 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:					

D. Diagnosis

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

E. TB Disease Classification

Bacteriological Status:	Drug Resistance Bacteriological Status:	Registration Group:
[ ] Bacteriologically-confirmed TB [ ] Clinically-diagnosed TB	[ ] Drug-susceptible [ ] Bacteriologically-confirmed RR-TB [ ] Bacteriologically-confirmed MDR-TB [ ] Bacteriologically-confirmed XDR-TB [ ] Clinically-diagnosed MDR-TB [ ] Other Drug-resistant TB _____	[ ] New [ ] TAF [ ] Relapse [ ] PTOU [ ] TALF [ ] Unknown History
Anatomical Site:		
[ ] Pulmonary [ ] Extra-pulmonary site: _____		

II. Treatment

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

A. Baseline Information

History of TB Treatment (most recent on top): [ ] None

Date Tx Started	Name of Treatment Unit	Treatment Regimen (Drugs & Duration)	Outcome

HIV Information:
[ ] Known PLHIV Prior to Start of Tx [ ] Not Eligible for Testing

HIV Test Date (MM/DD/YYYY):

Confirmatory Test Date (MM/DD/YYYY):

Result: [ ] P [ ] N [ ] undetermined
Started on ART? [ ] Yes [ ] No
Started on CPT? [ ] Yes [ ] No

Height: CM **Weight:** KG

Other Vital Signs or Treatment Considerations:

Person to Notify in case of Emergency:

Relationship:

Contact Information:

Diabetes Screening:
[ ] Known Diabetic [ ] Not Eligible

FBS Screening: mg/dl **Date Tested:**

4Ps Beneficiary?
[ ] Yes [ ] No

Co-morbidities: [ ] No Known

Date Diagnosed	Type	Treatment
	[ ] Diabetes Mellitus	
	[ ] Mental Illness	
	[ ] Substance Abuse	
	[ ] Liver Disease	
	[ ] Renal Disease	
	[ ] Other: _____	
	[ ] Other: _____	

Occupation:
[ ] HCW

B. Treatment Regimen

Regimen Type at Start of Treatment:
[ ] Regimen 1 2HRZE/4HR
[ ] Regimen 2 2HRZE/10HR

Treatment Start Date (MM/DD/YYYY):

Regimen Type at End of Treatment:

C. Treatment Outcome

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

Date of Outcome (MM/DD/YYYY):

Reason (if Failed, LTFU, or Died):

National TB Control Program

TB Case No. _____

Date Start (MM/DD/YYYY):	**Drug:**	4FDC	2FDC	H	R	Z	E	
	Strength:	150/ 75/ 400/ 275 mg	150/75 mg	mg	mg	mg	mg	
	Unit:	tablet	tablet					

E. Serious Adverse Events and AEs of Special Interest

Date of AE (MM/DD/YYYY)	**Specific AE**	**Date Reported to FDA** (MM/DD/YYYY)

D. Administration of Drugs

Location of Treatment:	**Name, Designation, and Type of Tx Supporter:**	**Tx Supporter Contact Information:**	[ ] DAT-supported
[ ] Facility-based [ ] Community-based [ ] Home-based	[ ] Facility HCW [ ] Community HCW [ ] Family [ ] Lay Volunteer [ ] Others	**Schedule of Treatment:**	**Name of DAT/s Used:**

Intensive Phase Start Date (MM/DD/YYYY):	**IP End Date** (MM/DD/YYYY):	**Continuation Phase Start Date** (MM/DD/YYYY):	**CP End Date** (MM/DD/YYYY):

#	**Month** (MMM-YY)	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	Monthly Doses Taken	Cum. Doses Taken	Monthly Missed Doses	% Adher.	Weight (kg)	Height (cm) for Children
0																																						
1																																						
2																																						
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Legend:

Tx Supporter 3-letter initials: Supervised
I: Incomplete Regimen
HOLD: On hold

STC/ TS/ CB/ HB: Satellite Treatment Center/ Treatment Site/ Community-Based/ Home-based DOT
X: Drugs not taken/ Absent
Re-challenge: Drug re-challenge

Encircle date of regimen change
Double slash on shift to CP
[brackets] – drugs dispensed to patient or treatment supporter

TB Case No. _____

F. Patient Progress Report Form

Month	Date	Problem (Adverse Event, Reason of Absence)	Action Taken	Plan	Health Staff Signature

G. Close Contacts

Name	Age	Sex (M/F)	Relationship	Initial Screening (MM/DD/YYYY)	Ff-up (MM/DD/YYYY)	Remarks (TB/ TPT Case Number)

H. Sputum Monitoring

	Date Collected (MM/DD/YYYY)	Smear Microscopy/ TB LAMP	Xpert MTB/RIF
S1			
S2			
B		/	
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

I. Chest X-ray

Month	Date Examined (MM/DD/YYYY)	Impression/ Comparative Reading	Descriptive Comments
B		[ ] Normal [ ] Abnormal suggestive of TB [ ] Abnormal not suggestive of TB	
		[ ] Improved [ ] Stable/Unchanged [ ] Worsened	
		[ ] Improved [ ] Stable/Unchanged [ ] Worsened	

J. Post Treatment Follow-up

Mo. After Tx	Date (MM/DD/YYYY)	CXR Findings	Smear/ Xpert	TBC & DST
PT				
PT				
PT				