FORM 4D. TB PREVENTIVE 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

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)**:** [ ] public [ ] other public [ ] private [ ] community	**Mode of Screening:** [ ] PCF [ ] ACF [ ] ICF [ ] ECF	**Date of Screening** (MM/DD/YYYY)**:**

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)**:**
[ ] TB Disease [x] TB Infection	**TPT Case Number:**	**Attending Physician:**	

E. Baseline Information

Height: CM	**Weight:** KG	**Person to Notify in case of Emergency:**	**Indication for TPT:**
Other Vital Signs or Treatment Considerations:		**Relationship:** **Contact Information:**	[ ] Household Contact [ ] Close Contact [ ] PLHIV [ ] Clinical Risk Group _____
Occupation:		**4Ps Beneficiary?** [ ] Yes [ ] No	

F. Treatment Regimen

Treatment Start Date (MM/DD/YYYY):	Regimen Type:	Date Start (MM/DD/YYYY):	Drug:	H	R	P	
	[ ] 6H [ ] 3HR [ ] 3HP [ ] 4R		Strength:				
			Unit:				

G. Treatment Outcome

Outcome:

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

Date of Outcome (MM/DD/YYYY):

Reason (if Failed, LTFU, or Died):

H. Administration of Drugs

Location of Treatment:

[ ] Facility-based
[ ] Community-based
[ ] Home-based

Name, Designation, and Type of Tx Supporter:

[ ] Facility HCW [ ] Community HCW [ ] Family [ ] Lay Volunteer [ ] Others

Tx Supporter Contact Information:

Schedule of Treatment:

[ ] DAT-supported

Name of DAT/s Used:

#	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																																						
3																																						
4																																						
5																																						
6																																						

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
[brackets] – drugs dispensed to patient or treatment supporter

I. Patient Progress

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

J. Serious Adverse Events and AEs of Special Interest

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