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](mailto: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

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| **I. Case Finding/ Notification** | | | | | | | | |
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| **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:** | | | **Sex** (M/F)**:** | **Civil Status:** |
|  | | |  | Years Months | | |  |  |
| **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:** | | | |
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| **B. Screening Information** | | | |
| **Referred by** (Name & Location)**:** | [ ] public [ ] other public [ ] private [ ] community | **Mode of Screening:** | **Date of Screening** (MM/DD/YYYY)**:** |
|  | | [ ] PCF [ ] ACF [ ] ICF [ ] ECF |  |

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

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| **II. Treatment** | | | |
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| **Name of Treatment Facility:** | **NTP Facility Code:** | **Province/ HUC:** | **Region:** |
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**A. Baseline Information**

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| **History of TB Treatment** (most recent on top)**:** | | | [ ] None | | **Height:** | **Weight:** | **Co-morbidities:** | [ ] No Known | | |
| **Date Tx Started** | **Name of Treatment Unit** | **Treatment Regimen**  (Drugs & Duration) | | **Outcome** | cM | Kg | **Date Diagnosed** | | **Type** | **Treatment** |
| **Other Vital Signs or Treatment Considerations:** | |
|  |  |  | |  |  | | [ ] Diabetes Mellitus |  |
|  | |
|  |  |  | |  |  | | [ ] Mental Illness |  |
|  |  |  | |  |  | | [ ] Substance Abuse |  |
|  |  |  | |  | **Person to Notify in case of Emergency:** | |  | | [ ] Liver Disease |  |
|  |  |  | |  | **Relationship:** | |  | | [ ] Renal Disease |  |
|  |  |  | |  |  | | [ ] Other: |  |
| **HIV Information:** | | | | |  | | [ ] Other: |  |
| **Contact Information:** | |
| [ ] Known PLHIV Prior to Start of Tx [ ] Not Eligible for Testing | | | | |
|  | |
| **HIV Test Date** (MM/DD/YYYY)**:** | | | | | **Diabetes Screening:** | |  | | | |
|  | | | | | [ ] Known Diabetic [ ] Not Eligible | |
| **Confirmatory Test Date** (MM/DD/YYYY)**:** | | | | | **FBS Screening:** | **Date Tested:** |
|  | | | | | mg/dl |  |
| **Result:**  **Started on ART? Started on CPT?** | [ ] P [ ] N [ ] undetermined  [ ] Yes [ ] No  [ ] Yes [ ] No | | | | **4Ps Beneficiary?** | | **Occupation:** | | | |
| [ ] Yes [ ] No | | [ ] HCW | | | |

**B. Treatment Regimen C. Treatment Outcome**

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| --- |
| **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:** |
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| **Outcome:** |
| [ ] Cured [ ] Failed [ ] Died [ ] Treatment Completed [ ] Lost to Follow-up |
| **Date of Outcome** (MM/DD/YYYY)**:** |
|  |
| **Reason** (if Failed, LTFU, or Died)**:** |
|  |

**E. Serious Adverse Events and AEs of Special Interest**

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| **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 |  |  |  |  |  |
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| **Date of AE**  (MM/DD/YYYY) | **Specific AE** | **Date Reported to FDA** (MM/DD/YYYY) |
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**D. Administration of Drugs**

Doses Taken

Taken

Missed Doses

for Children

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Location of Treatment:** | | | **Name, Designation, and Type of Tx Supporter:** | | | | | | | | | | | | | | | | | **Tx Supporter Contact Information:** | | | | | | | | | | | | [ ] DAT-supported  **Name of DAT/s Used:** | | | | | | | |
| [ ] Facility-based  [ ] Community-based [ ] Home-based | | | [ ] Facility HCW [ ] Community HCW [ ] Family [ ] Lay Volunteer [ ] Others | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| **Schedule of Treatment:** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **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)**:** | | | | | | | |
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| # | **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 | Cum. Doses | Monthly | % Adher. | Weight (kg) | Height (cm) |
| 0 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 2 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 10 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**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

**F. Patient Progress Report Form**

|  |  |  |  |  |  |
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| **Month** | **Date** | **Problem**  (ADverse Event, Reason oF Absence) | **Action Taken** | **Plan** | **Health Staff Signature** |
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**H. Sputum Monitoring**

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|  | **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**

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| **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 |  |

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| **G. Close Contacts** | | | | | | |
| **Name** | **Age** | **Sex**  (M/F**)** | **Relationship** | **Initial Screening** (MM/DD/YYYY) | **Ff-up**  (MM/DD/YYYY) | **Remarks** (TB/ TPT Case Number) |
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| **J. Post Treatment Follow-up** | | | | |
| **Mo. After Tx** | **Date** (MM/DD/YYYY) | **CXR Findings** | **Smear/ Xpert** | **TBC & DST** |
| PT |  |  |  |  |
| PT |  |  |  |  |
| PT |  |  |  |  |