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MINISTRY OF HEALTH-ETHIOPIA

# Health Centre /Clinic/Hospital Leprosy Register for Care After Completion of Treatment Register

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Region

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Zone/Subcity/Woreda

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Health Facility Name

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Begin Date

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End Date



### Leprosy register for care after completion of treatment

Sr. No.	Name	Sex	Classi-fication MB/PB	Date treatment completed	Type of the Reaction and date started	Type of care given			Is he/she organized in self care group (yes or no)
		Age				Protective foot wear	Type of medications or care given	Referred to hospital	
						Type of foot wear given		Reason for referral	
						RR or ENL	Size of foot wear	Type of care/medication	
Date	Date given	Date	Date						