MDR TB TREATMENT CARD

Federal Ministry of Health

FORM 01

PATIENT INFORMATION

Medical Registration Number(MRN): _____

MDR TB registration number: _____

Name: _____

Sex: ☐ M ☐ F

Age: _____

Region: _____

Zone/Woreda/House No : _____

Site: Pulmonary ☐ Extra Pul

If extra pulmonary, specify site:_____

Resistance type: RR/ MDR-TB / XDR-TB/ Poly resistant

Initial weight:_____ Height (CM): _____

Date treatment started(DD/MM/YY/):_____/ ____/ ____

Treatment Supporter

Name : _____

Full address :_____

Telephone:_____

Relationship :_____

Code	Registration group	Select one only
1	New	
2	Relapse	
3	After Lost to Follow up	
4	After failure of first treatment	
5	After failure of re treatment	
6	Transfer in (from another treatment initiating site)	
7	Other (previously treated with unknown outcome status)	

Medical Diagnosis other than tuberculosis

Type (i.e. diabetes, hypertension, cardiomyopathy, HIV, opportunistic infections….)	Duration in year

TB/HIV

HIV Testing done ☐ Y   ☐ N ☐ Unknown

Date of Test ____/____ /____Result: ____

Started on CPT(DD/MM/YY):____/____/____

Started on ART(DD/MM/YY):____/____ /____

Unique ART No._____

Drug-susceptibility testing (DST) results (Notation method for DST: R = Resistant, S = Susceptible, I = Indeterminate)

Date*	Diagnostic method	S	H	R	E	Z	Km	Am	Cm	Ofx	Pto	Eto	PAS	Cs	

Review panel meetings: Dates and Decisions

Date	Decision	Next date

Contacts Investigation (House Hold, Close contact)

Name	Relation (HH/CC)	MDR TB Screening (P/N)	DST result (No DR/RR/ MDR/XDR)

MDR TB Regimen (date treatment started and dosage (mg), change of dosage, and cessation of drugs)

Date	weight	Km/Am	Cm	Lfx	Mfx	Pto/ Eto	Cs	PAS	V.B 6	Z					Reason for drug change/discontinuation

Treatment outcome

Outcome	Cured	Completed	Died	Failed	Lost to follow up	Not Evaluated
Mark one						
Date(D/M/Y)						

Anti TB Drug Abbreviations

Group I		Group II		Group III		Group IV		Group V	
Isoniazid	H	Amikacin	Am	ofloxacin	Ofx	Prothionamide	Pto	Bedaquiline	Bdq
Rifampicin	R	Kanamycin	Km	Levofloxacin	Lft	Ethionamide	Eto	Linezoid	Lzd
Ethambutol	E	Capreomycin	Cm	Moxifloxacin	Mfx	Cyclosrine	Cs	Clofazimine	Cfz
Pyrazinamide	Z	Streptomycin	S			Pra amino Salicyclic acid	PAS	Amoxacillin	Amx
								High dose INH	H
								Thiocacetazone	Th

Chest x-ray

Result			
Base line			
	Improved(✔)	No change(✔)	Deteriorated (✔)
End of Intensive Phase			
End of Continuation			

Comments:

_____

_____

_____

_____

Month #	Sputum Smear Microscopy			Culture	
	Date*	Sample No.	Result	Sample No.	Result
Prior**					
0					
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					

Scheduled Laboratory Monitoring Table

Month#	Date	weight	ALT/ SGPT	AST/ SGOT	Creatinine	K	TSH	Hgb	WBC	Preg. test		
Prior**												
0												
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20												
21												
22												
23												
24												

* all dates in the tables that report smears, culture and DST dates the specimen was collected from the patient.
** the date the sputum was collected that led to the patient being registered with MDR TB(if performed)

NB: Write weight of the patient monthly on the space provided. Mark (✔) for scheduled laboratory investigation performed and attach the result in the patient file.

Adverse Effects(Write only the initial of the adverse effect requiring drug modification, the abbreviation of the suspect drug/s and date in the space provided)

Date(DD/MM/YY)															
Code															
Suspected drug															

NV.	Nausea &Vomiting	HL.	Hearing loss	J.	Jaundice	Ar	Arthralgia, Arthritis
G.	Gastritis	DA.	Depression Anxiety	RT.	Renal toxicity	O	Other than Listed
PN.	Peripheral neuropathy	PS.	Psychotic symptoms	ED.	Electrolyte disturbance		
S.	Seizures	HT.	Hypothyroidism	ON.	Optic neuritis		

Daily Drug Administration Monitoring Chart

Month(using Local calendar)	0	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

Mark in the boxes

    3=directly observed

    2=not supervised

    1=drugs not taken

Use the upper portion of the box to mark for morning dose and the lower portion for evening dose. Write appropriate code for the daily drug administration monitoring chart using the code written on the left side