REPUBLIC OF KENYA

MINISTRY OF HEALTH

Specimen

DR-TB Patient Treatment Log Book

Patient Name:

Patient Reg. No.:

Ministry of Health
National Tuberculosis, Leprosy and Lung Disease Program

September 2020
MOH/DPPH/DNTLD/ DRTBPTTreat.LOGBOOK/001

TABLE OF CONTENTS

Outcome	Definition
Cured	Treatment completed as recommended by the national policy without evidence of failure AND three or more consecutive cultures taken at least 30 days apart are negative after the intensive phase
Treatment Complete	Treatment completed as recommended by the national policy without evidence of failure BUT no record that three or more consecutive cultures taken at least 30 days apart are negative after the intensive phase
Died	A patient who dies for any reason before starting or during the course of treatment.
Treatment Failed	Treatment terminated or need for permanent regimen change of at least two anti-TB drugs because of: – Lack of conversion by the end of the intensive phase, *or* – Bacteriological reversion in the continuation phase after conversion to negative, *or* – Evidence of additional acquired resistance to fluoroquinolones or second-line injectable drugs, *or* – Adverse Drug Reactions (ADRs)
Lost to Follow Up	A patient who started treatment and interrupted for 2 consecutive months or more

CONTACTS SCREENING

Contacts are defined as persons living in the same household, or spending many hours together in the same indoor living space. Screen the contacts for TB symptoms and obtain a chest X-Ray at baseline. Close contacts of DR TB are at high risk of DR TB. Close contacts with TB should be treated as DR TB. Refer to the DR TB guidelines.Screen contacts for symptoms every 0 months(at time of diagnosis of the index case), 3 months, 6 months, 12 months, 18 months and 24 months. If a contact is found to have TB symptoms, obtain a chest X-Ray, genexpert FL LPA, SL LPA, and culture and DST. (Document this in the clinical notes section

					Date __ / __ / _____			Date __ / __ / _____	Date __ / __ / _____	Date __ / __ / _____	Date __ / __ / _____	Date __ / __ / _____	Date __ / __ / _____	Date __ / __ / _____
No.	Name	Age	Sex	Mobile No.	Are there TB symp-toms? (Y/N)	CXR	GeneXpert Results	Are there TB symp-toms? (Y/N)	Are there TB symp-toms? (Y/N)	Are there TB symp-toms? (Y/N)	Are there TB symp-toms? (Y/N)	Are there TB symptoms? (Y/N)	Are there TB symptoms? (Y/N)	Outcome TB/ No TB
						Key 1.Normal 2.Abnormal (Suggestive of TB) 3.Abnormal Others 4.Not done								

DR TB (CATEGORY IV) TREATMENT CARD

County:
Sub-County:
Health facility Name:
Patient Name:
Model of care(Community/Facility/Isolation):
Date of Registration:
Sub-County DR TB Registration Number:
Phone number: NHIF Reg No:
ID NO/NEMIS No: Occupation:
Place of Residence:
Nearest Landmark e.g school/ church/ mosque:
Sex: Male ☐ Female ☐
Age: Date of Birth: __/__/____
Initial Weight(kg): __ Height (cm): __ BMI/ BMI for Age/ Z score: ___
Treatment Supporter
Name:
Mobile Number:
Physical Address:
Medical History

Condition	Current Medication
Diabetes mellitus	
Renal Disease	
Liver Disease	
Convulsions, epilepsy	
Cardiovascular disease	
Psychiatric history	
Severe malnutrition	
Cancer	
Asthma/COPD	
Covid-19	
Other	
Other medications used	

Type of TB	Pulmomary		
	Extrapulmonary		
	Both		
	If Extrapulmonary, specify Sub type:		

Indicate Anti-TB medicines		Remarks/Comments
Isoniazid	☐	
Rifampicin	☐	
Ethambutol	☐	
Pyrazinamide	☐	
Streptomycin	☐	

	Registration Group	Select only one
1	New patient	☐
2	Relapse	☐
3	Return after loss to follow up	☐
4	After failure of 1st Line (FFT)	☐
5	After failure of retreatment	☐
6	Transfer In	☐
7	Others (previously treated without known outcome status)	☐

HIV Information

HIV Testing done: YES NO
Date of Test: ___/___/___ -ve☐ +ve☐
If positive, on ART:YES NO Date started: ___/___/
ART Regimen _____
CD4 count: Viral Load:
Patient CCC Number:
On CPT: YES/ NO Date started: ___/___/
Previously on TPT: Yes/No———
Key:ART- Antirotroviral therapy *TPT (TB Preventive Therapy)*
CPT=Cotrimoxazole preventive

Comorbidities and Risk factors	Tick as applicable
Smoking	
Alcoholism	
Drug and substance use	
Pregnancy	
Malnutrition	
COVID-19	
Others (Specify)	

Presenting complains	Tick as applicable
Cough	☐
Fever	☐
Shortness of breath	☐
Night sweats	☐
Weight loss/poor weight gain/Failure to thrive	☐
Chest pain	☐
Others (Specify)	

Previous Tuberculosis Treatment episodes			
Number of episodes	Start date (if unknown, put year)	Health Facility	Remarks

Previously used 2nd line drugs: YES NO Don't Know

If yes, tick as applicable below

BDQ	Bedaquiline	
Am	Amikacin	
Km	Kanamycin	
Cm	Capreomycin	
Cfx	Ciprofloxacin	
Lfx	Levofloxacin	
Mfx	Moxifloxacin	
Pto	Prothionamide	
Eto	Ethionamide	
Cs	Cycloserine	
PAS	Para Aminosalicilic Acid	
Cfz	Clofazimine	
Lzd	Linezolid	
DLM	Delamanid	
Aug	Augmentin	
Imp/ Cil	Imipenem/ Cilastatin	
INHh	High dose Isoniazid	

Obs/ Gyn history	
Last mensturation date _____/ _____/ _____ (dd/mm/yy)	
Parity _____	Gravidity _____
Contraceptive use: YES _____	Specify_____ NO _____
Social history	
Currently smoking _____	packs/ day, for _____
Currently drinking alcohol: drinks/day	years
Currently using addictive drugs: (specify)_____	
Employment status	**Marital status**
Unemployed	Married
Retired	Single
Student	Divorced
Occupation (specify)	Separated
	Widow(er)

Vital Signs	Functional status:	
BP _____/ _____	Able to conduct normal activity, No special care needed	
Pulse rate _____/ min	Unable to conduct normal activity, Some assistance needed	
Temp _____ oC	Unable to care for self, requires hospitalization	
Resp. rate _____/ min		
SpO2 _____(%)		

Systemic examination	
(Fill in the findings on systemic examination below as either normal or abnormal)	
Lymph nodes	
Cardiovascular system	
Respiratory system	
Abdomen	
Skin	
Urogenital system	
Musculoskeletal exam	
Neurological exam	
Other	

Baseline lab test results		
Test	**Date**	**Results**
Creatinine		
Bilirubin		
AST		
ALT		
Potassium		
Full haemogram		
TSH		
Pregnancy test		
Magnessium		
RBS		
Albumin		
CD4		
Viral Load		

Other Baseline tests		
Test	**Date**	**Results**
ECG (QTCF)		
Audiometry(Normal/Abnormal)		
Visual testing		
Ishihara test		
Snellen's test		

ANTHROPROMETRIC MEASUREMENTS

Date	Weight (kg)	Height/Length (m)	BMI (Above 18 years) BMI for age(5-17 years) Z score(0-59Months) (Refer to BMI charts)	Nutrition Support (Specify) (Refer to key below)	Comments

Nutrition support	code
Nutritional Counselling	**NC**
Therapeutic feeds	**RUTF**
Supplementary Feeds	**FBF**
Vitamin A	
Pyridoxine	
Not Done	**ND**

DR-TB TREATMENT OUTCOME		
Outcome	**Mark One**	**Date of Outcome**
Cured		
Treatment Complete		
Died		
Treatment Failed		
Lost to Follow Up		
Transferred Out		

ADHERENCE COUNSELING CHECKLIST

Questions	Baseline	Day 14	Day 28	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 13	Month 14	Month 15	Month 16	Month 17	Month 18	Month 19	Month 20
Date																						
Agreement between HCW and patient	****Tick appropriately****																					
Is the patient willing to receive DOTs?																						
Does the patient fully understand the duration of treatment?																						
Does the patients understand that the health care worker will retain confidentiality?																						
Does the patient understand the consequences of stopping/refusing treatment to themselves?																						
Does the patient understand the consequences of stopping/refusing treatment to their close contacts and general																						
Does the patient understand they can be put under involuntary isolation as a consequence of stopping/refusing treatment?																						
If the patient stopped/ refused TB treatment in the past, what will he/ she do differently this time in order to complete treatment?																						
Arrange with the patient																						
Does the patient understand the need to organise his/her priorities in order to better cope with changes and interruptions in social life?																						
Does the patient have a treatment supporter (caregiver or family member) that would participate in the sessions and help in treatment management?																						
Does the patient have a daily schedule and treatment plan for DOT?																						
Health care workers responsibility																						
Have you assisted the patient to evaluate the factors likely to interfere in the treatment and their solutions?																						
Will you be available for the patient to express his emotions and other psychological reactions?																						
Will you assist the patient to anticipate causes of treatment interruption and identify strategies to overcome them?																						
Have you applied the PHQ9 form to the patient?																						
If mental or substance abuse history, have you refered to appropriate care providers?																						

CONSENT FORM

Level	Information provided	Agreement
Agree between HCW and patient	Is the patient willing to receive DOTs?	Yes No
	Does the patient fully understand the duration of treatment?	Yes No
	Does the patients understand that the health care worker will maintain confidentiality?	Yes No
	Does the patient understand the consequences of stopping/refusing treatment to himself/herself?	Yes No
	Does the patient understand the consequences of Stopping/refusing treatmentto their close contacts and general public?	Yes No
	Does the patient understand that one of the consequences of Stopping/refusing treatment is involuntary isolation for the duration of treatment?	Yes No
Arrange with the patient	Does the patient understand the need to organize his/her priorities in order to better cope with changes and interruptions in social life	Yes No
	Does the patient have a treatment supporter (caregiver or family member) that will participate in the education/ counselling sessions and help in treatment management	Yes No
	Does the patient have daily schedule for taking his medication and treatment plan for DOT	Yes No
Health care workers responsibility	Have you helped the patient to evaluate the factors likely to interfere in the treatment and their solutions?	Yes No
	Will you be available for the patient to express his emotions and other psychological reactions?	Yes No
	Will you assist the patient to anticipate barriers to implementing treatment plan and identify strategies to overcome them?	Yes No
	Have you applied the PHQ9 and CAGE form to the patient?	Yes No
	Is there a history of mental illness or substance abuse? (If yes, refer to appropriate care providers)	Yes No

Patient/Guardian, next of kin/Guardian and health care workers memorandum of understanding for DR TB Treatment

I ..... (patient identified to have DR TB/Guardian)

And

..... (who is the Next of kin/Treatment supporter)

have been explained about DR-TB, the medicines to be used and associated adverse/side effects, the need to complete treatment and the duration of treatment.

We also understand the consequences of stopping/refusing treatment to self, close contacts and general public.

We have agreed that the patient will be started on DR TB treatment and we undertake to ensure that the patient will present themselves to the health facility (or allow a health worker to visit them daily) for the stipulated treatment period as advised by the health care worker.

We also undertake to ensure that the patient does not interrupt treatment under any circumstances. In case of interruption of treatment,we understand the applicable consequences, including involuntary isolation treatment for the patient in a health facility.

Sign:

Patient/Guardian..... Next of Kin .....

Date ..... Date:.....

Phone No:..... Phone No:.....

Witness (Health care worker):

Name :..... Cadre:.....

Sign:..... Date:.....

Phone No:.....

Facility official stamp .....

Reviewed

Subcounty TB Leprosy Coordinator

Name..... . Sign:.....

Date .....

Phone No:.....

1st and 2nd line Culture DST results (Phenotypic)												1st and 2nd line LPA DST Results (Genotypic)							
Date	S	H	R	E	Z	Km	Am	Cm	Fq	Pto/ Eto	Other		H	R	Km	Am	Cm	Fq	Other

GENEXPERT Results (*tick where applicable*)	
MTB	DETECTED
	NOT DETECTED
RIF	RESISTANT
	SENSITIVE

Notation method for DST
R-Resistance
S-Susceptible

Notation method for recording microscopy	
No AFB seen	0
1-9 AFB per 100 HPF	Scanty (Report no of AFB)
10-99 AFB per 100 HPF	+
1-10 AFB per HPF	++
>10 AFB per HPF	+++

Notation method for recording cultures	
Growth	G
No Growth	NG
Non tuberculous mycobacteria Isolated but no growth of MTB	NG (NTM)
Contaminated	C

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

LABORATORY AND CLINICAL FOLLOW UP

RESULTS

	TESTS:	Full heamogram				Bilirubin	AST	ALT	Serum Albumin	Creatinine	Magnesium	Potassium	CD4 Count	Viral load	TSH	Pregnancy test	ECG (GT interval)	Visual test	RBS	Other (specify)
		RBC	WBC	Platelets	HB															
Month of Treatment	Date																			
Baseline (Month 0)																				

AUDIOMETRY FOLLOW UP TOOL (if patient is on Aminoglycosides)

Month	Date	FREQUENCY (dbl)	500	1,000	2,000	3,000	4,000	6,000	8,000	Comments
0		Right								
		Left								
1		Right								
		Left								
2		Right								
		Left								
3		Right								
		Left								
4		Right								
		Left								
5		Right								
		Left								
6		Right								
		Left								
7		Right								
		Left								
8		Right								
		Left								
9		Right								
		Left								
10		Right								
		Left								
11		Right								
		Left								
12		Right								
		Left								

DR-TB REGIMEN MODIFICATION

Drug	Date treatment started	Initial Dosage	Date of Dose adjustement	Adjusted Dose	Reason for adjusting dosage	Date drug was substituted	Reason for drug substitution
Bedaquiline (Bdq)							
Levofloxacin (Lfx)							
Moxifloxacin (Mfx)							
Linezolid (Lzd)							
Clofazimine (Cfz)							
Cycloserine (Cs)							
Delamanid (Dlm)							
Isoniazid (Inh)							
Rifampicin (Rif)							
Ethambutol (Emb)							
Pyrazinamide (Pza)							
High Dose Isoniazid (Hh)							
Prothionamide (Pto)							
Ethionamide (Eto)							
Para-Aminosalicylic Acid (PAS)							
Kanamycin (Km)							
Amikacin (Amk)							
Capreomycin (Cm)							
Imipinem (Imp)							
Amoxy-Clavulanic Acid (Amx/Clav)							
Indicate type of contraception (for females)							

DAILY OBSERVATION OF DRUG INTAKE

Month:																														Reason for missed drug
Date:	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	
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Prothionamide (Pto)																																
Ethionamide (Eto)																																
Para-Aminosalicylic Acid (PAS)																																
Kanamycin (Km)																																
Amikacin (Amk)																																
Capreomycin (Cm)																																
Imipinem (Imp)																																
Amoxy-Clavulanic Acid (Amx/Clav)																																

Mark in the boxes	O	Daily Observed
	N	Not Supervised
	X	Drug not taken

Comments:

DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

		Month _____/Year _____																													Enter code from key below	
	Date:	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	Management	Outcome
	Side Effect_____																																	
1	Nausea																																	
2	Vomiting																																	
3	Abdominal pain																																	
4	Palpitation																																	
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15	Discoloration of skin and mucus membrane																																	
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20	Tinnitus																																	
21	Tremors																																	
	Others (list)_____																																	
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Side effect grading
Grade 0 - No side effect.
Grade 1 - Mild symptoms that don't interrupt normal functioing but requiring reassurance.
Grade 2 - Moderate symptoms causing greater than some interfernce in normal functioning. Requires monitoring and reassurance.
Grade 3 - Severe symptoms causing limitation in normal functioning. Requires clinical intervention including regimen modification.
Grade 4 - Potentially life threatening symptoms causing inability to perform. Requires hospitalisation for management.

Management	Outcome
1 Drug withdrawn	1 Recovering/Resolving
2 Dose reduced	2 Recovered/Resolved
3 Dose not changed	3 Requires prolonged hospitalization
4 Patient reassured	4 Causes congenital anomaly
5 Patient hospitalized	5 Permanent disability/morbidity
	6 Not resolved
	7 Unknown

DAILY OBSERVATION OF DRUG INTAKE

Month:																														Reason for missed drug
Date:	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	
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Imipinem (Imp)																																
Amoxy-Clavulanic Acid (Amx/Clav)																																

Mark in the boxes	O	Daily Observed
	N	Not Supervised
	X	Drug not taken

Comments:

DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

		Month _____/Year _____																													Enter code from key below	
	Date:	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	Management	Outcome
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	6 Not resolved
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DAILY OBSERVATION OF DRUG INTAKE

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Mark in the boxes	O	Daily Observed
	N	Not Supervised
	X	Drug not taken

Comments:

DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

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	N	Not Supervised
	X	Drug not taken

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DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

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Grade 3 - Severe symptoms causing limitation in normal functioning. Requires clinical intervention including regimen modification.
Grade 4 - Potentially life threatening symptoms causing inability to perform. Requires hospitalisation for management.

Management	**Outcome**
1 Drug withdrawn	1 Recovering/Resolving
2 Dose reduced	2 Recovered/Resolved
3 Dose not changed	3 Requires prolonged hospitalization
4 Patient reassured	4 Causes congenital anomaly
5 Patient hospitalized	5 Permanent disability/morbidity
	6 Not resolved
	7 Unknown

DAILY OBSERVATION OF DRUG INTAKE

Month:																															Reason for missed drug
Date:	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	
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Amoxy-Clavulanic Acid (Amx/Clav)																																

Mark in the boxes	O	Daily Observed
	N	Not Supervised
	X	Drug not taken

Comments:

DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

		Month _____/Year _____																													Enter code from key below	
	Date:	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	Management	Outcome
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Management	**Outcome**
1 Drug withdrawn	1 Recovering/Resolving
2 Dose reduced	2 Recovered/Resolved
3 Dose not changed	3 Requires prolonged hospitalization
4 Patient reassured	4 Causes congenital anomaly
5 Patient hospitalized	5 Permanent disability/morbidity
	6 Not resolved
	7 Unknown

DAILY OBSERVATION OF DRUG INTAKE

Month:																														Reason for missed drug
Date:	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	
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Mark in the boxes	O	Daily Observed
	N	Not Supervised
	X	Drug not taken

Comments:

DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

		Month _____/Year _____																													Enter code from key below	
	Date:	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	Management	Outcome
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Management	**Outcome**
1 Drug withdrawn	1 Recovering/Resolving
2 Dose reduced	2 Recovered/Resolved
3 Dose not changed	3 Requires prolonged hospitalization
4 Patient reassured	4 Causes congenital anomaly
5 Patient hospitalized	5 Permanent disability/morbidity
	6 Not resolved
	7 Unknown

DAILY OBSERVATION OF DRUG INTAKE

Month:																														Reason for missed drug
Date:	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	
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Mark in the boxes	O	Daily Observed
	N	Not Supervised
	X	Drug not taken

Comments:

DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

		Month _____/Year _____																													Enter code from key below	
	Date:	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	Management	Outcome
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Management	**Outcome**
1 Drug withdrawn	1 Recovering/Resolving
2 Dose reduced	2 Recovered/Resolved
3 Dose not changed	3 Requires prolonged hospitalization
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5 Patient hospitalized	5 Permanent disability/morbidity
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DAILY OBSERVATION OF DRUG INTAKE

Month:																														Reason for missed drug
Date:	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	
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Mark in the boxes	O	Daily Observed
	N	Not Supervised
	X	Drug not taken

Comments:

DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

		Month _____/Year _____																													Enter code from key below	
	Date:	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	Management	Outcome
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1 Drug withdrawn	1 Recovering/Resolving
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DAILY OBSERVATION OF DRUG INTAKE

Month:																														Reason for missed drug
Date:	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	
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Mark in the boxes	O	Daily Observed
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	X	Drug not taken

Comments:

DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

		Month _____/Year _____																													Enter code from key below	
	Date:	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	Management	Outcome
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DAILY OBSERVATION OF DRUG INTAKE

Month:																														Reason for missed drug
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Comments:

DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

		Month _____/Year _____																													Enter code from key below	
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Comments:

DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

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Comments:

DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

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Grade 4 - Potentially life threatening symptoms causing inability to perform. Requires hospitalisation for management.

Management	**Outcome**
1 Drug withdrawn	1 Recovering/Resolving
2 Dose reduced	2 Recovered/Resolved
3 Dose not changed	3 Requires prolonged hospitalization
4 Patient reassured	4 Causes congenital anomaly
5 Patient hospitalized	5 Permanent disability/morbidity
	6 Not resolved
	7 Unknown

DAILY OBSERVATION OF DRUG INTAKE

Month:																														Reason for missed drug
Date:	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	
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Mark in the boxes	O	Daily Observed
	N	Not Supervised
	X	Drug not taken

Comments:

DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

		Month _____/Year _____																													Enter code from key below	
	Date:	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	Management	Outcome
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Management	**Outcome**
1 Drug withdrawn	1 Recovering/Resolving
2 Dose reduced	2 Recovered/Resolved
3 Dose not changed	3 Requires prolonged hospitalization
4 Patient reassured	4 Causes congenital anomaly
5 Patient hospitalized	5 Permanent disability/morbidity
	6 Not resolved
	7 Unknown

DAILY OBSERVATION OF DRUG INTAKE

Month:																														Reason for missed drug
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Mark in the boxes	O	Daily Observed
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	X	Drug not taken

Comments:

DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

		Month _____/Year _____																													Enter code from key below	
	Date:	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	Management	Outcome
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Management	**Outcome**
1 Drug withdrawn	1 Recovering/Resolving
2 Dose reduced	2 Recovered/Resolved
3 Dose not changed	3 Requires prolonged hospitalization
4 Patient reassured	4 Causes congenital anomaly
5 Patient hospitalized	5 Permanent disability/morbidity
	6 Not resolved
	7 Unknown

DAILY OBSERVATION OF DRUG INTAKE

Month:																														Reason for missed drug
Date:	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	
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Mark in the boxes	O	Daily Observed
	N	Not Supervised
	X	Drug not taken

Comments:

DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

		Month _____/Year _____																													Enter code from key below	
	Date:	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	Management	Outcome
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Management	**Outcome**
1 Drug withdrawn	1 Recovering/Resolving
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DAILY OBSERVATION OF DRUG INTAKE

Month:																														Reason for missed drug
Date:	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	
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Mark in the boxes	O	Daily Observed
	N	Not Supervised
	X	Drug not taken

Comments:

DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

		Month _____/Year _____																													Enter code from key below	
	Date:	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	Management	Outcome
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DAILY OBSERVATION OF DRUG INTAKE

Month:																														Reason for missed drug
Date:	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	
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Mark in the boxes	O	Daily Observed
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	X	Drug not taken

Comments:

DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

		Month _____/Year _____																													Enter code from key below	
	Date:	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	Management	Outcome
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DAILY OBSERVATION OF DRUG INTAKE

Month:																														Reason for missed drug
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Comments:

DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

		Month _____/Year _____																													Enter code from key below	
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DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

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Comments:

DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

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Management	**Outcome**
1 Drug withdrawn	1 Recovering/Resolving
2 Dose reduced	2 Recovered/Resolved
3 Dose not changed	3 Requires prolonged hospitalization
4 Patient reassured	4 Causes congenital anomaly
5 Patient hospitalized	5 Permanent disability/morbidity
	6 Not resolved
	7 Unknown

DAILY OBSERVATION OF DRUG INTAKE

Month:																														Reason for missed drug
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Imipinem (Imp)																																
Amoxy-Clavulanic Acid (Amx/Clav)																																

Mark in the boxes	O	Daily Observed
	N	Not Supervised
	X	Drug not taken

Comments:

DAILY DR-TB DRUG SIDE EFFECT MONITORING FORM

		Month _____/Year _____																													Enter code from key below	
	Date:	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	Management	Outcome
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2 Dose reduced	2 Resolved
3 Dose not changed	3 Requires prolonged hospitalization
4 Patient reassured	4 Causes congenital anomaly
5 Patient hospitalized	5 Permanent disability/morbidity
	6 Not resolved
	7 Unknown

CLINICAL NOTES

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MONTHLY DR TB CLINICAL REVIEW TEAM CHECKLIST

1. **To be filled by the chair of the review team**
2. **Confirm and put a tick against each variable carried out**

		Base line	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
1	Date																									
2	Record age in years																									
3	Record weight at current visit																									
4	Record BMI at current visit																									
5	Nutrition support given Y/N																									
6	Record follow up tests reviewed at visit depending on month of treatment (audiometry, hgm, LFTs, UECs, CXR, LFTs, CD4, repeat																									
7	Blood drawn for Lancet Labs Y/N																									
8	Screen for clinical symptoms of common ADRs (and complete the daily DR TB side effect monitoring form) Y/N																									
9	ADR forms filled and reported to county pharmacist Y/N																									
10	Drug adjustments made Y/N																									
11	Record reasons for drug adjustment e.g. weight gain, weight loss, ADR																									
12	Record date drugs adjusted																									
13	Record results of latest monthly smear microscopy																									
14	Record results of latest monthly culture																									
15	Where applicable, any ART adjustments made to dosage? Y/N																									
16	Record date adjustment made																									
17	Record reason for ART adjustments e.g. ADR, ART Resistance																									
18	Patients received monthly support Y/N																									
19	Has the patient been enrolled with NHIF ?																									
20	Where applicable DOTS nurse received monthly transport support Y/N																									
21	DR TB Tx Counselling done? Y/N																									

National Tuberculosis, Leprosy and Lung Disease Program

1st Floor, Afya Annex, Kenyatta National Hospital Grounds
P.O. Box 20781 – 00202 Nairobi

Email: info@nltp.co.ke

www.nltp.co.ke

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