

**REPUBLIC OF KENYA**



**MINISTRY OF HEALTH**

# DR-TB Patient Treatment Log Book

**Patient Name:**

**Patient Reg. No.:**

**VERSION 2020**



# TABLE OF CONTENTS

DR-TB Treatment Outcome.....	1
Contacts Screening .....	2
DR TB (Category IV) Treatment Card.....	3
Anthropometric Measurements.....	6
Consent Form .....	8
Laboratory and Clinical Follow Up.....	9
Audiometer Follow up Tool.....	10
DR-TB Regimen Modification .....	11
Daily Observation of Drug Intake.....	12
Daily DR TB Drug Side Effect Monitoring Form.....	13
Clinical Notes.....	53
Monthly DR TB Clinical Review Team Checklist.....	54

## DR-TB TREATMENT OUTCOME

<u>Outcome</u>	<u>Mark one</u>	<u>Date of outcome</u>
Cured		
Treatment Complete		
Died		
Treatment Failed		
Lost to follow up		
Transferred out		

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 DR TB 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 TB patient who started treatment and interrupted for 2 consecutive months or more





Obs/ Gyn history	
Last menstruation date ____/____/____ (dd/mm/yy)	
Gravidity _____	Parity _____
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 <input type="checkbox"/>
Pulse rate _____/ min	Unable to conduct normal activity, Some assistance needed <input type="checkbox"/>
Temp _____ oC	Unable to care for self, requires hospitalization <input type="checkbox"/>
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		
Magnesium		
RBS		
Albumin		
CD4		
Viral Load		
Other Baseline tests		
Test	Date	Results
ECG (QTCF)		
Audiometry(Normal/Abnormal)		
page 3)		
Visual testing		
Ishihara test		
Snellen's test		

### ANTHROPOMETRIC MEASUREMENTS

Month No.	Date*	Weight (kg)	Height (m)	BMI (Above 18 years) BMI for age(5-17 years) Z score(0-59Months) (Refer to BMI charts)	Nutrition Support (Refer to key below)	Comments
Baseline						
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						

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

## ADHERENCE COUNSELING CHECKLIST

Questions	Baseline	Day 14	Day 28	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month8	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																						
<b>Agreement between HCW and patient</b>	****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 public?																						
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?																						
<b>Arrange with the patient</b>																						
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?																						
<b>Health care workers responsibility</b>																						
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 referred to appropriate care providers?																						



## CONSENT FORM

Level	Information provided	Agreement
<b>Agree between HCW and patient</b>	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 treatment to their close contacts and general public?	Yes No
<b>Arrange with the patient</b>	Does the patient understand that one of the consequences of Stopping/refusing treatment is involuntary isolation for the duration of treatment?	Yes No
	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 <u>treatment management</u>	Yes No
<b>Health care workers responsibility</b>	Does the patient have daily schedule for taking his medication and treatment plan for DOT	Yes No
	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 is 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.	
<b>Sign:</b>	
Patient/Guardian.....	Next of
Kin.....	
Date .....	Date:.....
Phone No:.....	Phone No:.....
<b>Witness (Health care worker):</b>	
Name :.....	Cadre:.....
Sign:.....	Date:.....
Phone No:.....	
Facility official stamp .....	
<b>Reviewed</b>	
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	
Follow up Smear Microscopy results												Follow up Culture results								
GENEXPERT Results (tick where applicable)			Month No.	Sputum smear microscopy			Month No.	Sputum smear microscopy			Month No.	Culture			Month No.	Culture				
MTB	DETECTED			Date	Sample No.	Result		Date	Sample No.	Result		Date	Sample No.	Result		Date	Sample No.	Result		
	NOT DETECTED		0				13				0				13					
RIF	RESISTANT		1				14				1				14					
	SENSITIVE		2				15				2				15					
Notation method for DST			3				16				3				16					
R- Resistance			4				17				4				17					
S= Susceptible			5				18				5				18					
Notation method for recording Microscopy			6				19				6				19					
No AFB seen			7				20				7				20					
1- 9 AFB per 100 HPF			8				21				8				21					
Scanty (Report no of AFB)			9				22				9				22					
10- 99 AFB per 100 HPF			10				23				10				23					
+			11				24				11				24					
1- 10 AFB per HPF			12								12									
>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																		



**AUDIOMETRY FOLLOW UP TOOL (if patient is on Aminoglycosides)**

Month	Date	FREQUENCY (db)	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 adjustment	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			
Bedaquiline (Bdq)																																		
Levofloxacin (Lfx)																																		
Moxifloxacin (Mfx)																																		
Linezolid (Lzd)																																		
Clofazimine (Cfz)																																		
Cycloserine (Cs)																																		
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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			
<b>Side Effect</b>																																					
1	Nausea																																				
2	Vomiting																																				
3	Abdominal pain																																				
4	Palpitation																																				
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21	Tremors																																				
<b>Others (list)</b>																																					
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Side effect grading
Grade 0 - No side effect.
Grade 1 - Mild symptoms that don't interrupt normal functioning but requiring reassurance.
Grade 2 - Moderate symptoms causing greater than some interference 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	4 Permanent disability/morbidity
	5 Not resolved
	6 Unknown
	7

### 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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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			
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Side effect grading
Grade 0 - No side effect.
Grade 1 - Mild symptoms that don't interrupt normal functioning but requiring reassurance.
Grade 2 - Moderate symptoms causing greater than some interference 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	4 Permanent disability/morbidity
	5 Not resolved
	6 Unknown
	7

### 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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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				
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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	4 Permanent disability/morbidity
	5 Not resolved
	6 Unknown
	7

### 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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Side effect grading
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Grade 3 - Severe symptoms causing limitation in normal functioning. Requires clinical intervention including regimen modification.
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Management	Outcome
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4 Patient reassured	4 Causes congenital anomaly
5 Patient hospitalized	4 Permanent disability/morbidity
	5 Not resolved
	6 Unknown
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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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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				
	<b>Side Effect</b>																																					
1	Nausea																																					
2	Vomiting																																					
3	Abdominal pain																																					
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Side effect grading
Grade 0 - No side effect.
Grade 1 - Mild symptoms that don't interrupt normal functioning but requiring reassurance.
Grade 2 - Moderate symptoms causing greater than some interference 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	4 Permanent disability/morbidity
	5 Not resolved
	6 Unknown
	7

### 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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3 Dose not changed	3 Requires prolonged hospitalization
4 Patient reassured	4 Causes congenital anomaly
5 Patient hospitalized	4 Permanent disability/morbidity
	5 Not resolved
	6 Unknown
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### DAILY OBSERVATION OF DRUG INTAKE

Month: .....																																Reason for missed drug		
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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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3 Dose not changed	3 Requires prolonged hospitalization
4 Patient reassured	4 Causes congenital anomaly
5 Patient hospitalized	4 Permanent disability/morbidity
	5 Not resolved
	6 Unknown
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### DAILY OBSERVATION OF DRUG INTAKE

	Month: .....																															Reason for missed drug							
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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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5 Patient hospitalized	4 Permanent disability/morbidity
	5 Not resolved
	6 Unknown
	7

### 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
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4 Patient reassured	4 Causes congenital anomaly
5 Patient hospitalized	4 Permanent disability/morbidity
	5 Not resolved
	6 Unknown
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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						
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### DAILY OBSERVATION OF DRUG INTAKE

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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					
	<b>Side Effect</b>																																						
1	Nausea																																						
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3	Abdominal pain																																						
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Side effect grading
Grade 0 - No side effect.
Grade 1 - Mild symptoms that don't interrupt normal functioning but requiring reassurance.
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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	4 Permanent disability/morbidity
	5 Not resolved
	6 Unknown
	7

### 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	4 Permanent disability/morbidity
	5 Not resolved
	6 Unknown
	7

### 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	4 Permanent disability/morbidity
	5 Not resolved
	6 Unknown
	7

### 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	4 Permanent disability/morbidity
	5 Not resolved
	6 Unknown
	7

### 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	4 Permanent disability/morbidity
	5 Not resolved
	6 Unknown
	7

### 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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5 Patient hospitalized	4 Permanent disability/morbidity
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	6 Unknown
	7

### DAILY OBSERVATION OF DRUG INTAKE

	Month: .....																															Reason for missed drug		
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Mark in the boxes	O	Daily Observed
	N	Not Supervised
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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

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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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4 Patient reassured	4 Causes congenital anomaly
5 Patient hospitalized	4 Permanent disability/morbidity
	5 Not resolved
	6 Unknown
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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				
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)																																			

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

Comments:



# 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

		Baseline	Month 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, seizures, peripheral neuropathy, hearing impairment, psychotic symptoms, hypo thyroidism, nausea, vomiting, gastritis, hepatitis, renal failure, electrolyte imbalance, optic neuritis, arthralgias 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 e.t.c																									
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																									
	DR TB Tx Counselling done? Y/N																									





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