MDR-TB Treatment Monthly Follow-Up Form **Month_____ Date _____/_____/_____**

Name_____ **Registration No. _____**

I. Medical Presentation

Fever Yes □ No □
Weight Loss Yes □ No □
Cough Yes □ No □
Hemoptysis Yes □ No □
Dyspnea Yes □ No □

Other symptoms:

Pulmonary TB	Yes □ No □
Extrapulmonary TB	Yes □ No □
HIV Coinfection	Yes □ No □

Record all new events or changes in pre-existing conditions since last interview

Event	Date onset	Date resolved	Outcome§	Severity≠	Seriousness&	Rechallenges¥

§ Outcome
R1 Recovered/resolved
R2 Recovering/resolving
S Recovered with sequalae
N Not recovered/not resolved
D Died
U Unknown

≠Severity
1 Mild
2 Moderate
3 Severe

& Seriousness
N Not serious
H Hospitalization
P Permanent disability
C Congenital abnormality
L Life threatening
D Death

¥ Rechallenges
1 No rechallenges
2 Recurrence of event
3 No recurrence
4 Result unknown

Side Effect	Question to Ask Patient	Patient Response	Action Taken
Hearing loss	Are you having trouble hearing?	Yes □ No □	
Tinnitus and dizziness	Do you have any ringing in your ears or dizziness?	Yes □ No □	
Nausea	Have you had nausea the last week?	Yes □ No □	
Vomiting	Have you vomited in the last month?	Yes □ No □	
	Have you vomited up your medications?	Yes □ No □	
Diarrhea	Have you had diarrhea in the last month?	Yes □ No □	
Abdominal pain	Have you had abdominal pain?	Yes □ No □	
	Have you had black stools or vomited blood?	Yes □ No □	
Anorexia	Do you have a poor appetite?	Yes □ No □	
Neuropathy	Have you had pain or burning in your legs?	Yes □ No □	
Low potassium	Have you had leg cramping?	Yes □ No □	
	Do you feel weak?	Yes □ No □	
Depression	Do you feel sad?	Yes □ No □	
	Do you have thoughts of committing suicide?	Yes □ No □	
Anxiousness	Do you feel anxious or agitated?	Yes □ No □	
Psychosis	Do you hear voices or see things that may not be there?	Yes □ No □	
Hepatitis	Have you noticed yellowing of your eyes or your skin?	Yes □ No □	
Allergy	Do you have any rashes?	Yes □ No □	
Joint pain	Do you have any joint pain?	Yes □ No □	

Name_____ **Registration No.** _____

II. Co-morbidities

Diabetes Yes □ No □ Chronic kidney disease Yes □ No □ Chronic liver disease Yes □ No □

Pregnant Yes □ No □ Uncertain □ Date of LMP:_____ or estimated current gestation_____

Breastfeeding Yes □ No □

III. Contact Tracing

Family members with fever, weight loss, cough, dyspnea: Yes □ No □

Relationship: _____

IV. Socio-economic Issues

Social or economic issues that could interrupt treatment: Yes □ No □

Comments:

V. Physical Examination

Temp_____°C BP _____/_____ Pulse _____/min RR _____/min Weight_____ kg Height _____cm

Physical exam normal: Yes □ No □

Abnormal physical findings:

VI. Laboratory Results

Potassium		Magnesium		Calcium		Creatinine		Creatinine Clearance	
Date		Date		Date		Date		Date	
Date		Date		Date		Date		Date	

ALT (SGPT)		AST (SGOT)		Bilirubin		Albumin		Glucose	
Date		Date		Date		Date		Date	
Date		Date		Date		Date		Date	

WBC		Hematocrit		Platelets		CD4			
Date		Date		Date		Date		Date	
Date		Date		Date		Date		Date	

Most recent sputum smear: Date _____ Negative □ Positive □ (Result _____)

Most recent sputum culture: Date _____ Negative □ Positive □ (Result _____)

VII. Electrocardiogram Date_____ (DD-MM-YY) Heart Rate_____ QT_c interval_____

Note: $QT_c = QT / \sqrt{(60 / \text{heart rate})}$

Name_____ **Registration No.** _____

VIII. Treatment

Medications taken since last interview (list anti-TB meds first)	Dosage	Frequency	Route	Adherence in past month[≠]	Continuing medication?	Reason, if stopping[#]	Stop date
					Yes □ No □		
					Yes □ No □		
					Yes □ No □		
					Yes □ No □		
					Yes □ No □		
					Yes □ No □		
					Yes □ No □		
					Yes □ No □		
					Yes □ No □		
					Yes □ No □		
					Yes □ No □		
					Yes □ No □		
					Yes □ No □		

≠ Adherence
A >90% doses taken
N ≤90% doses taken

Reasons for stopping
1 Adverse event
2 Poor adherence
3 Course completed
4 Planned interruption
5 Planned medication change
6 No longer needed
7 Pregnancy
8 Drug out of stock
9 Cost
10 Patient decision
11 Died
12 Lost to follow-up
13 Other: _____

Medications taken since last interview (list anti-TB meds first)	Dosage	Frequency	Route	Start date	Indication

IX. Assessment and Plan

Date of next appointment _____/_____/_____

Clinician's signature_____

Clinician's name (block letters) _____ Date_____(DD-MM-YY)