Tuberculosis Disease Initial Phase Treatment

Hospital/other clinic start	Y	N	LAB	Y	N
Date: ___/___/___ **TBPCP START** Date: ___/___/___ Weight _____			CP (Bili & Enzymes) CBC HIV (pre-test counseled) Other: Date _____ Initials_____		
•Client/Client guardian verbalizes understanding of TB disease & medication regimen. •Treatment begins.			**DV EVALUATION** DV (+) ☐ DV (?) ☐ DV (-) ☐ DV (NA) ☐		

SYMPTOM REVIEW	Y	N
Cough		
Hemoptysis		
Fever / Chills		
Night Sweats		
↓ Appetite		
Weight Loss		
Fatigue/Weakness		
SIDE EFFECTS		
Nausea / vomiting		
Abdominal pain		
Jaundice skin / eyes		
Brown/dark urine		
Skin rash		
Numb hands / feet		
Joint Pain		
Fatigue/Weakness		
Bleeding/Easy Bruising		
Blood in urine		
Flu like symptoms		

EDUCATION	Y	N
•TB treatment agreement •Instructions for DOT •Med card given •Consent for photo •Literature_____ _____ _____		

VISION	HIV POST TEST
Ishihara (OU)_____ OD (Rt) _____ OS (Lt) _____ OU (both)_____ Nurse Initials_____	**Counseled** **Date** _____ Nurse Initials_____

Monthly Evaluation

Date: ____/____/____

Weight _____

Monthly Evaluation

Date: ____/____/____

Weight _____

SYMPTOM REVIEW	Y	N	SYMPTOM REVIEW	Y	N
Cough			Cough		
Hemoptysis			Hemoptysis		
Fever / Chills			Fever / Chills		
Night Sweats			Night Sweats		
↓ Appetite			↓ Appetite		
Weight Loss			Weight Loss		
Fatigue/Weakness			Fatigue/Weakness		
SIDE EFFECTS			**SIDE EFFECTS**		
Nausea / vomiting			Nausea / vomiting		
Abdominal pain			Abdominal pain		
Jaundice skin / eyes			Jaundice skin / eyes		
Brown/dark urine			Brown/dark urine		
Skin rash			Skin rash		
Numb hands / feet			Numb hands / feet		
Joint Pain			Joint Pain		
Fatigue/Weakness			Fatigue/Weakness		
Bleeding/Easy Bruising			Bleeding/Easy Bruising		
Blood in urine			Blood in urine		
Flu like symptoms			Flu like symptoms		

VISION	VISION
Ishihara (OU) _____ OD (Rt) _____ OS (Lt) _____ OU (both) _____ Nurse Initials _____	Ishihara (OU) _____ OD (Rt) _____ OS (Lt) _____ OU (both) _____ Nurse Initials _____

End of Initial Phase

Approximate Date ___/___/___

Continuation Phase Start Date ___/___/___

Client chooses biweekly days:
Monday/Thursday Tuesday/Friday (circle one)

Review DOT requirements ☐ Yes ☐ No

Return unused meds to pharmacy ☐ Yes ☐ No

Nurses Initials: _____

_____

Key:
- CXR =Chest x-ray
- E =Evaluation
- S =Sputum
- CP =Chem Panel
- CBC =Complete Blood Count
- Sx =Symptom Review
- CA =Communication alert
- V =Video Phone

DRUG ALLERGIES

_____

_____

_____

Transcribed by:	Check for MD/Routine Order																																											
Date ordered	Dose Number		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	32	33	34	35	36	37	38	39	40		
	Date dose given																																											
Prescription	mg/pill	#																																										
		See Nurses Notes																																										

Last Name _____ **First Name** _____ **DOB** _____ **Age** _____ **Sex** ☐ **Male** ☐ **Female** **Language** _____ **Interpreter needed** ☐ **Yes** ☐**No**

Last Name _____ **First** _____ **DOB** _____

Nurse initials / signatures				Interpreter initials / signatures	

Sputum collection

DATE														
Given/Received														
Initials														

Lab

Test Ordered															
Date done															
Site															
Initials															

Chest x-ray

Date CXR Auth given							**MD Clinic Dates:**	
Initials								

Communication alert for upcoming visits