HOUSEHOLD CONTACTS

Name of contact	Age	Symptom Screened		Treatment started			
				IPT		TB	
		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	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	Yes	No
		Yes	No	Yes	No	Yes	No

TREATMENT OUTCOMES

Treatment stop date: d d m m y y y y

- ☐ **Cured**
- ☐ **Treatment Completed**
- ☐ **Lost to follow up**
- ☐ **Failed treatment** ☐ **MDR-TB** ☐ **Rif Resistant TB**
- ☐ **Died**

REFERRALS

☐ Moved out ☐ Transferred out Date: d d m m y y y y

Name of receiving clinic: _____

Town/ District: _____

Province/ Country: _____

Discharged by (Print name): _____

G.PS. 004-2575

GW 20/12
2018

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

TB TREATMENT RECORD

Facility Name: _____ District: _____

Patient Folder Number: _____

TB Registration Number:

- N Newly Registered in this facility
- M Moved in from facility in this district
- T Transferred in from another district

Facility Name: _____
TB Reg No: _____

Name:

Surname:

PATIENT DETAILS

ID Number/Date of birth: y y m m d d _ _ _ _ _ _ _ Age ☐ Gender M F

PHYSICAL ADDRESS

Home Address:	Name of Company/ Employer:
	Work address:
Tel No./Cellphone:	Tel No:

PATIENT CATEGORY

- ☐ New
- ☐ Relapse
- ☐ Re-treatment after Loss to follow up
- ☐ Re-treatment after Failure
- ☐ Other Previously Treated

CLASSIFICATION OF DISEASE

ICD10 Code ☐

Pulmonary TB ☐
Extra Pulmonary TB ☐
Site of disease _____

☐ Rifampicin susceptible TB ☐ Isoniazid resistant TB

TREATMENT REGIMEN

☐ Regimen 1 ☐ Regimen 3 ☐ Other Specify: _____

Treatment Start Date d d m m y y y y

NEXT OF KIN or FRIEND DETAILS

Surname _____ First Name(s) _____ Phone Number _____
Address: _____

NOTIFICATION INFORMATION (GW17/5)

Has the GW17/5 form been completed? Y N Notification date: d d m m y y y y

XPERT, LINE PROBE ASSAY, CULTURE, DST RESULTS

GENEXPERT						
Date	**Result**			**Rifampicin Susceptibility Results**		
	Positive	Negative	Unsuccessful	Resistant	Susceptible	Unsuccessful
	Positive	Negative	Unsuccessful	Resistant	Susceptible	Unsuccessful
	Positive	Negative	Unsuccessful	Resistant	Susceptible	Unsuccessful

LINE PROBE ASSAY (LPA)							
Date	**Result**			**Drug Susceptibility Results**			
				Rifampicin		**Isoniazid**	
	Positive	Negative	Contaminated	Resistant	Susceptible	Resistant	Susceptible
	Positive	Negative	Contaminated	Resistant	Susceptible	Resistant	Susceptible

CULTURE							
Date	**Culture Result**			**Drug Susceptibility Test (DST) Results**			
				Rifampicin		**Isoniazid**	
	Positive	Negative	Contaminated	Resistant	Susceptible	Resistant	Susceptible
	Positive	Negative	Contaminated	Resistant	Susceptible	Resistant	Susceptible

SMEAR MICROSCOPY RESULTS

Date	**Baseline**		**End of continuation phase**				**End of treatment**	
			7 weeks		**11 weeks**		**23 weeks**	
	Result		**Result**		**Result**		**Result**	
	Positive	Negative	Positive	Negative	Negative	Positive	Negative	Positive
	Positive	Negative	Positive	Negative	Negative	Positive	Negative	Positive
	Positive	Negative	Positive	Negative	Negative	Positive	Negative	Positive
	Positive	Negative	Positive	Negative	Negative	Positive	Negative	Positive

OTHER DIAGNOSTIC TESTS CONDUCTED

X-rays:

Findings:

Other tests conducted/ performed:

Test results:

MEDICAL HISTORY

KNOWN MEDICAL CONDITIONS			CURRENT MEDICATION
Hypertension	Yes	No	
Diabetes	Yes	No	
Epilepsy	Yes	No	
Mental illness	Yes	No	
Liver disease	Yes	No	
Renal insufficiency	Yes	No	
Allergies (specify)			
Other (specify)			

Last menstrual period: _____ **Contraceptive method:** _____

HIV INFORMATION

HIV Status	Pos	Neg	Unk
On Cotrimoxazole	Yes	No	N/A
On ART	Yes	No	N/A

HIV Test conducted: **Yes** **No** **If yes, result:** _____
(Circle where applicable)

If on ART, Regimen: _____

RISK FACTORS

	Pos	Neg
Tobacco use		
Alcohol use	Yes	No
Substance use	Yes	No

Assess for severity

Has the patient ever:

Worked in a mine	Yes	No
Spent time in prison	Yes	No
Been admitted in hospital	Yes	No

(Refer to occupational health clinic/ MBOD if ex mineworker)

TREATMENT

INTENSIVE PHASE (IP)

Body weight at start of IP _____ kg

Medicine	**RHZE (150/75/400/275)**	***RHZ (75/50/150)**	**RH (60/60)**	**R**	**H**	**Z**	**E**	**S**
No. of tablets/ dosage per day								

* New formulation

Month	**Date**																																**No.of Doses taken**
	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		

Ö = patient took medication
x = patient did not take medication
— = medication collected for self administration or supervision elsewhere

CONTINUATION PHASE (CP)

Body weight at start of CP _____ kg

Medicine	**RH (150/75)**	**RH (300/150)**	***RH (75/50)**	**RH (60/60)**	**R**	**H**	**E**
Number of tablets/ dosage per day							

* New formulation

Month	**Date**																																**No.of Doses taken**
	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		

Ö = patient took medication
x = patient did not take medication
— = medication collected for self administration or supervision elsewhere