Patient's code:

FORM FOR COLLECTION INITIATION INFORMATION OF MDR-TB PATIENT

PATIENT DETAILS

Full name:	**Sex:** ☐ M ☐ F	**Date of birth:** ____ /____ / _____	**Address:**	**Height:** cm	**Weight:** kg
Register N º MDR-TB:	**ID No:**	**Occupation:**	**Local TB facility:**		

Patient classification:
☐ New
☐ Recurrence
☐ Failure I
☐ Failure II
☐ Treatment after losing to follow-up
☐ Transfer from another facility
☐ Other_____

Patient situation:
☐ Pregnant
☐ Breastfeeding an infant
☐ Alcohol abuse
☐ Drug abuse
☐ Malnitrition
☐ Other_____
☐ None

Other disease:
☐ Epilepsy
☐ Psychosis
☐ Anaemia
☐ Diabetes
☐ Renal failure
☐ Liver failure
☐ Digestive disease
☐ Eye disease
☐ Auditory disease
☐ Musculoskeletal disease
☐ Thyroid gland disease
☐ Autoimmune Diseases
☐ Other_____
☐ None

HIV test
☐ HIV(+) using ARV drugs
☐ HIV(+) without treatment
☐ HIV(-)
☐ No infomation

History of drug allergy ☐**Yes** ☐ **No**
If yes, please specify:

Resistance TB- drugs (excluding isoniazid and rifampicin):
☐ Streptomycin ☐ Capreomycin
☐ Ethambutol ☐ Ofloxacin
☐ Pyrazinamid ☐ Other
☐ Amikacin
☐ Kanamycin

HISTORY OF DRUG USE (within 30 days before treatment start)			**EVENTS (within 30 days before treatment start)**					
Drug	**Dosage**	**Frequency**	**Test**	**Date**	**Result**	**Test**	**Date**	**Result**
			RBC(G/l)			Kali (µmol/l)		
			Hb (g/dl)			Magie (µmol/l)		
			WBC (G/l)			Acid uric (µmol/l)		
			PLT(G/l)			Creatinin (µmol/l)		
			ALT (SGPT) (IU/l)			Ure (mmol/l)		
			AST (SGOT) (IU/l)			TSH (µU/l)		
			Total bilirubin (µmol/l)			Other		
			Unconjugated bilirubin					

MDR-TB TREATMENT INFORMATION

Starting date: **Regimen:** ☐ IVA ☐ IVB ☐ Other

MDR TB drugs	**Dosage**	**Frequency**	**Other drugs**	**Dosage**	**Frequency**

Reporting date: **Reporter:** **Phone number:**

FORM 2 Patient's code:

:

FORM FOR COLLECTION SUSPECTED ADVERSE DRUG REACTION (ADR) INFORMATION

MDR-TBfacility:_____ District :_____

Patient's name:_____ Sex: □ Male □ Female Weight:_____kg Date of birth:_____/_____/_____ Register number:_____ ID number:_____	Month:_____ Date: _____/_____/20_____ Patient situation: □ Inpatient □ Monthly re-examination □ Unsheduled re-examination
Monthly re-examination:	□ No ADR □ ADR happened

1. Treatment change

1.1 Change the regimen: □ Yes □ No

(If No, go to 1.4)

1.2. If Yes:

Changed drug	New drugs
1.	1.
2.	2.
3.	3.
4.	4.

1.3. Reasons:

□ Having ADE □ Poor compliance □ Run out of drug

□ Treatment failure □ Prenancy □ Serious diseases

□ Other

_____

1.4. Using other drugs: □ Yes □ No

If Yes:_____

_____ _____

2. ADE

Conventional codes *(Check the codes and fill the blanks)*

Seriousness

0 = Not serious
1 = Death
2 = Life threatening
3 = Requires or prolongs hospitalization
4 = Disability or permanent damage
5 = Congenital anomaly/ birth defect
6 = No information

ADR treatment

0= No treatment
1 = Reducing dose
2 = Stopping drug
3 = Changing regimen
4 = Drug to treat ADR *(please specify)* :
41 = Histamin antagonist (please specify)
42 = Coticoid (please specify)
43 = Adrenalin
44 = Other, please specify

5 Renal dialysis
6 Transfer from another facility

7 No information

99 Other _____
_____

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	ADE	Appearance	Date	Seriousness	Treatment
1	**Nausea, vomiting**	☐			
2	***Diarrhoea***	☐			
3	***Abdominal pain***	☐			
4	***Anorexia***	☐			
5	***Gastritis*** *(Multichoice)*	☐			
	1. Heartburn	☐			
	2. Epigastric pain	☐			
	3. Results gastroscopy (specify results)	☐			
6	***Hepatotoxicity*** *(Multichoice)*	☐			
	1. Jaundice, yellow eyes	☐			
	2. Dark urine	☐			
	3. Pale stools	☐			
	4. The right upper quadrant abdominal pain	☐			
	5. Itchy	☐			
	6. ASAT, ALAT increasing ASAT =_____(U/l) ALAT =	☐			
	7. Bilirubin increasing Total Bilirubin = (µmol/l) Unconjugated Bilirubin = _____(µmol/l)	☐			
7	***Headache***	☐			
8	***Dizziness, vertigo***	☐			
9	***Seizures, epilepsy***	☐			
10	***Psychosis*** *(Multichoice)*	☐			
	1. Hallucinations, auditory hallucinations	☐			
	2. Confusing thoughts	☐			
	3. Odd behavior	☐			
	4. Depression	☐			
	5. Insomnia	☐			
	6. Losing focus	☐			
	7. Having suicidal	☐			
11	***Peripheral neuropathy***	☐			
	Finger and toe numbness	☐			
12	***Arthralgia***	☐			
13	***Allergic reaction*** *(Multichoice)*	☐			
	1. Rash	☐			
	2. Itchy	☐			
	3. Hypersensitive skin with light	☐			

	Biến cố bất lợi	Appearance	Date	Serious	Treatment
14	***Nephrotoxic*** *(Multichoice)*	☐			
	1. Retention of urine	☐			
	2. Oedema	☐			
	3. Creatinine increasing (specific result) Creatinine = (µmol/l)	☐			
	4. Urea increasing Urea = _(mmol/l)	☐			
15	***Vestibular - auditory disorders*** *(Multichoice)*	☐			
	1. Blurred hearing/ deaf	☐			
	2. Vestibular Disorders	☐			
16	***Visual disturbances*** *(Multichoice)*	☐			
	3. Blurred vision	☐			
	4. Dificulty in distinguishing colors	☐			
17	***Hypothyroidism*** *(Multichoice)*	☐			
	1. Thyroid hypertrophy	☐			
	2. Constipation	☐			
	3. Weight gain	☐			
	4. Dry skin, dry hair	☐			
	5. Intolerant of cold	☐			
	6. Husky speaking	☐			
	7. Slow pulse	☐			
	8. Menstrual Disorders (in women), sexual disorders (in men)	☐			
	9. TSH increasing (*specific result*) TSH = _(µU/l)	☐			
	10. T3, T4 decreasing (*specific result*) T3 = _____(nmol/l) T4 = _____(nmol/l)	☐			
18	***Potassium decreasing*** *(specific result)* K+ = _(mmol/l)	☐			
19	***Uric acid increasing*** *(specific result)* Uric Acid = _____(µmol/l)	☐			
20	***Rối loạn huyết học*** *(Multichoice)*	☐			
	1. Anemia (*specific result)* Hb = _(g/dl)	☐			
	2. Neutropenia (*specific result)* WBC = (x 10^9/l)	☐			
	3. Thrombocytopenia (*specific result)* PLT = _____ (x 10^9/l)	☐			
21	***Endocrine disorders*** *(Multichoice)*	☐			

	Biến cố bất lợi	Appearance	Date	Serious	Treatment
	1. Breast enlargement (in males)	☐			
	2. Physiological dysfunction (in men)	☐			
	3. Menstrual Disorders (in women)	☐			
22	***Reactions at the injection site*** *(Multichoice)*	☐			
	1. Pain	☐			
	2. Swollen	☐			
	3. Callosity	☐			
	4. Itchy	☐			
23	***Anaphylaxis*** *(Multichoice)*	☐			
	1. On skin *(rash,itchy and* vasodilation*...)*	☐			
	2. On répiratory *(Dyspnea, tracheal constriction...)*	☐			
	3. Hypotension	☐			
	4. On gastrointestinal (stomach cramps, diarrhea	☐			
99	***Other***	☐			

Date:	**Signature:**	**Phone number:**
___/_____/ 20_____		