

नेपाल सरकार

स्वास्थ्य व्यवस्थापन सूचना प्रणाली

औषधी प्रतिरोधी क्षयरोग उपचार व्यवस्थापन कार्ड

DR TUBERCULOSIS TREATMENT MANAGEMENT CARD

बिरामीको नाम:

स्वास्थ्य संस्थाको नाम:

जिल्ला: नगरपालिका/गाउँ पालिका: वडा नं.:

प्रयोग मिति: अर्थिक वर्ष: सम्म

DRTB Reg. No:				Registrati	on Date: d	d/mm/yyyy							Patient	under CB	DOT				1		TB HI\	/ Status		
Patient Name:				<u> </u>	Age	γ	1.Fem	ale	2. Male	Weight:			i 1 1 1 1	Н	eight:	CM				HIV Inf	ection		Patie	ents on
Provinc	ce	 	Districts	:	i	M/RN	Л:	L-	Ward No	Tole			<u> </u>						<u> </u>	1.Pos			ART	СРТ
DOT/Provider:				L			Guardian's	Name a	nd Phone										1	2.Neg 3. Unk				
No.of Household	Member			No.	of <5 years	s children :	<u>i</u> 	IN	lo.of HH m	nembers s	creened f	or TB:				C	 Co-morbidi	ty:	<u> </u>					
			Regist	raion Cate	gory: 1. Ne	ew 2. Rel	apse 3.1 T	 ΓΑF*(New	_FLD) 3	.2 TAF(Re	reatment	_FLD)	3.3 TAF(Ret _l	Hr TB) 3	.4 TAF (2n	id line) 4	. TALF**	5. OPT*	** 6. UF	PTH***				
Type: 1. RR/MDR	(SSTR)	2. RR/ N	IDR (LTR) 3. Pr	e- XDR 4.)	 (DR			Site of TI	B: Pulmo	 nary				EP(Spec	ify								
DST Result	Н	R	Z	Е	Mfx	Mfxh	Lfx		Bdq	L	zd	Cs	s	cfz	,	AM	E	ito	D	lm				
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Follow up Date																								
Follow up Date																							 	
			RR/MDR ((SSTR)					RR/ MDR	(I TR)					Pre- XI)R					x	(DR		
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Outcome: 1.cu	ıred	2. Con	npleted	3.	Failed		4. Died		5. Loss to fol	llow-up	6 N	lot Evaluat	ed			Date:								
H=Isoniazid, R=Rifam	picin, Z=P	yrazinamide	, E=Etham	nbutol, Mfx=l	Moxifloxacin,	CM=Capred	mycin, Lfx=L	evofloxacin						closerine, [Del=Delamar	nid, Bdq=Be	edaquiline,	AM=Amikad	cin					
6						12					tment Co		follow-up											
Month		Lab No/date		SR	Mo	onth		o/date		SR	Moi		Lab No/date		SR		24 Month		Lab N	No/date			SR	
*TAF = Treatment After Fa	ilure **TALF=	Treatment Afte	er Loss to follo	ow up ***OPT =	Other Perviously	/ Treatmentfollo	wup ****UPTH =	Unknown Prev	rious TB Treatm	nent History														

जाती कोडः १ दलित, २ जनजाती, ३ मधेशी, ४ मुस्लीम, ५ ब्राह्मण/क्षेत्री, ६अन्य

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H= Isoniazid, R= Rifampicin, Z= Pyrazinamide, E= Ethambutol, Mfx= Moxifloxacin, CM= Capreomycin,,Lfx= Levofloxacin, Eto=Ethionamide, Cfz=Clofazimine,Lzd= Linezolide, CS= Cycloserine, ,Del=Delamanid,Bdq= Bedaquiline, AM= Amikacin , Pass= Amx-Clv, IP-Cln

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Section on ABC Smoking Cessation At start of TB treatment then at follow-up examination visit: Ask Brief advice given to patient (30 seconds-1 minute) Cessation support provided to patient (1-3 minutes) Date Do you smoke?* Yes / No Month of Does anyone smoke Treatment Yes / No If Yes inside your home? Yes / No 1 = yes 2 = Comments Comments Yes / No 1 = Yes 2 = No How soon after you wake do you usually have DD/MM/YY No no Have you smoked at all-even a 1 = yes 2 = no your first cigarette? 1 = <30 min or 2 = >30puff—in the last 2 weeks? min **Months** S 2 2 2 1 1 Months S 2 2 R Q 1 1 2 1 Months S R Q 2 2 1 2 Months S 2 R Q 2 1 1 2 Months S R Q 1 2 1 2 1 2 Months S 2 R Q 2 2 1 Months S R Q 2 2 1 1 1 2 Months S 2 2 R Q 1 1 1 2 Months S R Q 2 1 2 1 2 1 Months S R Q 2 2 2 1 1 1 Months S R 2 Q 2 2 1 Months S Q 2 2 R 1 1 2 Months S 2 R Q 2 1 1 2 1 Months S R Q 1 2 2 1 2 Months S R Q 2 2 2 1 1 1 Months S Q 2 2 R 2 1 Months S R Q 1 2 1 2 1 2 Months S R Q 2 1 2 2 1 1 Months S Q 2 2 R 1 1 2

*Definitions for status of smoking

Months

S = current smoker: has smoked in the last 2 weeks before the visit and has not made any quit attempt since the last visit (quit attempt = patient tried to quit and succeeded for at least 24 hours).

Q

R

S

2

1

2

1

2

1

R = relapsed smoker: has smoked in the last 2 weeks before the visit but has made at least one quit attempt of at least 24 hours since the last visit.

Q = quitter: has not smoked at all in the last 2 weeks before the visit, not even a puff

Investigations	Baco lino	F/U Months	E/II Months	F/U Months	F/U Months	F/U Months	F/U Months	ns and Result	F/U Months	E/I Months	E/I L Months	F/U Months	F/U Months	F/U Months	F/U Months
nvestigations	Result														
CBC .	Date														
	Result														
Blood Glucose	Date														
	Result														
ECG _	Date														
	Result														
_FT -	Date														
	Result														
RFT -	Date														
	Result														
Jric Acid	Date														
	Result														
Hep B	Date														
	Result														
Hep C	Date														
	Result														
Audiometry	Date														
Peripherial	Result														
Neuropathy	Date														
	Result														
Visual Acuity -	Date														
	Result														
Pregnancy	Date														
	Result														
Kray –	Date														
	Result														
Other	Date														
Other	Result														
	Date Result	Date	Date Result	Date Result	Date	Date Result	Date Result	Date Result	Date	Date Result	Date Result	Date	Date Result	Date	Date Result
Other	Date	Result Date	Date	Date	Result Date	Date	Date	Date	Result Date	Date	Date	Result Date	Date	Result Date	Date

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							Follow-up of Sid	le-Effect							
Side Effect		F/U Months	F/U Months		F/U Months	F/U Months	F/U Months	F/U Months	F/U Months	F/U Months	F/U Months	F/U Months	F/U Months	F/U Months	F/U Months
Nausea/Vomiting	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
Diarrhoea	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
Arthralgia	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
Dizziness/ Vertigo	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
Hearing Disturbances	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
Vision Problem	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
Signs of Hypothyroidism	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
Minor mood changes or insomnia	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
Depression	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
Suicidal thoughts	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
Hallucinations/ Psychosis	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
Urine Output	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
Itchy skin	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
Jaundice	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
Seizures	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
Anaemia	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
Others	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
others	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
others	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
others	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
								•							

Note: Based on the Side Effect Identified please fill the aDSM form (HMIS 6.10)

	Signed at Treatment Center	Signed at Treatment Sub-Center	
Patient commitment		Sub-centre DR-TB focal person commitment	
end of my treatment. If I do no health of family and communit	e cured of this form of tuberculosis, I need to take anti-TB drugs daily till the ot take these drugs daily, I am putting my own health at risk as well as the ty members. I commit to taking these drugs at this health center (subment. If I decide to leave this treatment, I understand the risk and e.	I have explained the importance of taking these drugs and potential difficulties during tromposed to support him/her in completing a full course of treatment and getting cured. I ensuring proper documentation and reporting as per NTP guidelines	
Name:	Address:	Name: Address:	
Date:		Date:	
	Signature:	Signature:	
Treatment center DR-TB foo	cal person commitment	Treatment provider Commitment	
my best to support him/her in	ice of taking these drugs and potential difficulties during treatment. I will do completing a full course of treatment and ensuring cure/completion. I also cumentation and reporting as per NTP guidelines	I commit to supporting his/her in completing a full course of treatment. I will encourage with the treatment and commit to informing the treatment sub-center if I know that s/he taking drugs.	
Name:	Address:	Name: Address:	
Date:		Date:	
	Signature:	Signature:	

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