



BC Centre for Disease Control
An agency of the Provincial Health Services Authority

Patient name: _____
DOB: _____
TB#/PHN#: _____

Prophylaxis: Notification of Abnormal AST

Current AST: _____ Date: _____

Previous AST: _____ Date: _____

Baseline AST: _____ Date: _____

Please check the following categories that apply:

1) Abnormal AST greater than 45 and less than 100 and **NO** symptoms of liver toxicity*

- No change to medication
- Will repeat AST in 2 weeks

2) Abnormal AST greater than 45 and less than 100 **WITH** symptoms of liver toxicity*

- Medication stopped: Date _____
- Will repeat AST weekly until less than 45

Contact TB Control

3) Abnormal AST equal to or greater than 100

- Medication stopped: Date _____
- Will repeat AST weekly until less than 45

Contact TB Control

Comments: _____

Fax copy of form to TB Control
TB Vancouver: (604) 707-2690
TB New Westminster: (604) 707-2694

Contact TB Control for advice on re-starting medication.

***Symptoms of liver toxicity:**

Rash	Headache	Nausea
Vomiting	Diarrhea	Jaundice
Malaise	Fever	Abdominal Pain