Tuberculosis Adherence and Medication Re-order Form

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

Last Name:	**Treatment Regimen:**	**Address of Health Centre/Agency:**
First Name:	☐ Active TB ☐ Latent TB (Rifampin x 4 months) ☐ Latent TB (Isoniazid x 9 months) ☐ Latent TB (Isoniazid & Rifapentine x 3 months) ☐ Non-Tuberculous Mycobacterium (NTM)	
DOB (yyyy/mm/dd):		
PHN:		**Nurse:**___________________________
Allergies:	**Start Date** (yyyy/mm/dd):________________	**Phone Number:**___________________

Medication Adherence (not required for NTM):

Month	1	2	3	4	5	6	7	8	9*
Dates yyyy/mm/dd - yyyy/mm/dd									
Medications Taken / Given									

Comments (e.g., interruptions, side effects, concerns):

Medication Re-Order:

Date Given* (yyyy-mm-dd)	Drug name in full (no abbreviations)	Prescription (Rx) Number §	Order? Yes	Order? No ϴ	AST Date & Result	Faxed to TB Services (yyyy/mm-dd) and signature

* Start new form if treatment goes beyond 9 months or when you run out of lines
§ Located on prescription label after "Rx" (e.g., BC0000…)
ϴ Check "No" for end of treatment

Please fax completed form to TB Services every two months AND at completion (604) 707-2690

Revised July 2018