# TB Treatment Completion Form

## Client Name

<table>
<thead>
<tr>
<th>LAST</th>
<th>FIRST</th>
</tr>
</thead>
</table>

## Health Card Number or Client ID

<table>
<thead>
<tr>
<th>Address of Health Centre / Health Unit</th>
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## Date of Birth

<table>
<thead>
<tr>
<th>YYYY/MM/DD</th>
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## Fax

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<th>__________________________</th>
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## Treatment Regimen

- □ TB Disease (Active)
- □ Non-Tuberculous Mycobacterium (NTM)
- □ TB Preventive Treatment (TPT)
  - □ Rifampin 4 months
  - □ Isoniazid & Rifapentine 12 weeks
  - □ Isoniazid 9 months

## Treatment Dates

<table>
<thead>
<tr>
<th>Start Date</th>
<th>YY/MM/DD</th>
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</thead>
<tbody>
<tr>
<td>End Date</td>
<td>YY/MM/DD</td>
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## Major Mode of Treatment

- □ Directly Observed Therapy (DOT)
- □ Directly Observed Preventive Therapy (DOPT)
- □ Self-Administered Therapy (SAT)

## Treatment Outcome

(Not required for NTM)

# doses taken ____ (divided by) # days ____ (=) ____ treatment adherence (%)

## Comments:

## Reason Treatment Ended

- □ Adherent
- □ Left BC – within Canada
- □ Non-adherent
- □ Deceased
- □ Left Canada
- □ Other: __________
- □ Drug Reaction / Intolerance
- □ Lost to follow-up
- □ Unknown

## End of Treatment CXR

- TPT: Confirm TB Services (TBS) recommends an exit CXR.
  - □ Yes, a CXR is indicated and a requisition was provided to client
    - Date: ________________
    - Location: ____________________
  - □ No, an exit CXR is not recommended

- TB Disease (Pulmonary): Prior to stopping treatment, confirm end of treatment date with TBS
  - □ Yes, a CXR was completed in the last month of proposed treatment
    - Date: ________________
    - Location: ____________________

## Treatment Summary

Reason for TB screening ________________________________

Changes in prescription No □ Yes □_____________________

Interruptions No □ Yes □_____________________________

Unresolved side effects No □ Yes □_____________________

Ongoing AST elevation No □ Yes □______________________

Barriers to successful treatment No □ Yes □______________________

## Instructions

- Clients with abnormal AST at the end of treatment need weekly ASTs until result returns to baseline.
- Fax completed form along with the final TB Adherence and Medication Re-Order Form to the TB Services Program serving your area.

| BC Centre for Disease Control (604) 707-2690 | First Nations Health Authority (604) 689-3302 | Island TB Services (250) 519-1505 |