Treatment Completion Form

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

Last Name:	**Treatment Regimen:** ☐ 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) **Start Date** (yyyy/mm/dd): ___________________ **End Date** (yyyy/mm/dd): ___________________	**Address of Health Centre/Agency:** **Nurse:**___________________ **Phone Number:**_________________
First Name:		
DOB (yyyy/mm/dd):		
PHN:		

Major Mode of Treatment	☐ Directly Observed Therapy (DOT) ☐ Directly Observed Preventative Therapy (DOPT) ☐ Self-Administered Therapy (SAT)	☐ Treatment Completed ☐ Treatment Not Completed
Adherence (not required for NTM)	☐ 100% ☐ 80 – 89% ☐ 50 – 79% ☐ < 50% ☐ Adherence Unknown	Number of doses taken during treatment: __________________________
Reason Treatment Ended	☐ Adherent ☐ Deceased ☐ Drug Reaction / Intolerance ☐ Left BC – within Canada ☐ Left Canada ☐ Lost to follow-up	☐ Non-adherent ☐ Other _____________ ☐ Unknown
End of Treatment CXR	LTBI: ☐ Exit CXR requirement confirmed with TB Services ☐ CXR indicated, requisition provided to client Active TB (Pulmonary): ☐ CXR completed in last month of proposed treatment **(Confirm end of treatment with TB Services prior to stopping)** Date and location (if known) ___________________________________	
Treatment Summary	Please include: 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 ☐, ________________________	

Clients with abnormal AST at the end of treatment should have weekly AST's until returns to baseline

Please fax completed form along with final TB Adherence and Medication Re-order Form to TB Services (604) 707-2690