Treatment Initiation Form

BC Centre for Disease Control
Provincial Health Services Authority

Last Name:	**Treatment Regimen:**	LTBI Regimen Preference (if applicable):	**Address of Health Centre/Agency:**
First Name:	☐ Active TB ☐ Latent TB (LTBI) ☐ Non-Tuberculous Mycobacterium (NTM)	☐ Rifampin (4 months) ☐ Isoniazid (9 months) ☐ Isoniazid & Rifapentine (3 months)	**Nurse:**_____
DOB (yyyy/mm/dd)**:**	☐ **Refused therapy**		**Phone Number:**_____
PHN / Client ID#:			

Consent to Treatment Plan:

Client	☐ I was provided with education on the reason for treatment, the pills needed and their side effects. ☐ I have had an opportunity to ask questions. ☐ I agree to take pills as directed, and will report side effects if they occur. ☐ I agree to attend appointments for blood work, tests, and follow-up. ☐ I give BCCDC TB Services access to PharmaNet for information related to my TB treatment.

Client signature: _____ Date: _____

Clinical Details

Chest X-Ray	**Date** (yyyy/mm/dd): _____ ☐ Normal ☐ Abnormal	**AST/ALT**	**Date** (yyyy/mm/dd): _____ **Result**: _____U/L	**Weight**	_____(kg)

Current Medications	Notes: Please include best possible medication history including over-the-counter, herbal and other supplements, or non-prescribed substances for non-medical use.		
Allergies	Medication / Food / Environmental	Reaction	Severity
Comments	**Potential barriers and resources available to support client plan of care** (e.g., lack of transportation):	**Co-existing Conditions:**	
	Other:		

Co-ordinating Health Unit/Centre is responsible for:

- Dispensing medications, monitoring side effects, and ensuring required blood work and CXR's are completed. TB Adherence and Medication Re-Order Form.
- Baseline and ongoing monitoring of visual acuity and red/green discrimination for clients taking ethambutol.
- Reporting any abnormal AST/ALT results to TB Services. Notification of Abnormal AST Form.

Ordering process may take up to 1-2 weeks

Please fax completed form to TB Services (604) 707-2690