Royal College of Nursing

TB Treatment (Form: 2)

Form 2: TB Treatment (complete at commencing TB treatment for active disease OR latent infection) clinic:

NHS no:	Hospital no:	Case manager:	Consultant:
Last name:	Other names:	LTBR / ETS no:	DOB: / /
Address (Usual place of residence or "where can be found") Telephone		GP details	

Diagnosis (tick all known at Rx start)

☐ **Active Pulmonary TB**
Smear: (date: ___/___/_____)
☐ positive ☐ negative
☐ not done ☐ unknown
Culture: (date: ___/___/_____)
☐ positive ☐ negative
☐ not done ☐ unknown

☐ **Active Extra-Pulmonary TB**
Smear: (date: ___/___/_____)
☐ positive ☐ negative
☐ not done ☐ unknown
Culture: (date: ___/___/_____)
☐ positive ☐ negative
☐ not done ☐ unknown

☐ **Latent TB infection**
☐ recent exposure known
☐ recent exposure unknown

Site of disease (tick any for Active TB cases)

☐ Pulmonary
☐ Lymph node
☐ CNS
☐ Bone
☐ Spinal
☐ Milliary
☐ Other (below)

Drug resistance risk factors [AUDIT G]

☐ Previous TB treatment (year:_____)
(where:_____ for how long:_____)
☐ Contact of known resistant case
☐ Problem drug use (ever)
☐ Problem alcohol use (ever)
☐ Imprisonment (ever)

Drug sensitivity (tick any as known)

☐ Fully sensitive
☐ Isoniazid resistant
☐ Rifampicin resistant
☐ Ethambutol resistant
☐ Pyrazinamide resistant
☐ Other_____

Weight (kg) (at Rx start) : BMI:	**LFT's** (Baseline) Normal ☐ Abnormal ☐ Not done ☐	**Snellen:** aided/unaided Left _____ Right _____	Other relevant clinical issues
Visual acuity Date tested: / / NAD ☐ Not done ☐ No ETH ☐ Abnormal ☐ Referred to eye clinic **Yes** ☐ **No** ☐		**Ishihara:**	

Planned treatment regimen start: / /	**Planned date continuation phase:** / /	**Estimate treatment completion:** / /
Actual Treatment start: / /	**Continuation phase date:** / /	**Treatment completion date:** / /

☐ 2 (RHZE) 4 (RH) – Standard short course Rx
☐ 2 (RZSE) 7 (RE) – Isoniazid res. known at start
☐ 2 (RZE) 10 (RE) - Isoniazid res. known after start
☐ 2 (RHZE) 10 (RH) - Central Nervous System
☐ 6 (Isoniazid) - Latent TB
☐ 3 (Rifinah) - Latent TB
☐ 6 (Rifampicin) - Latent TB
☐ Pyridoxine

Other TB/regular medication:

Possible drug interactions:

OPD F/U appointments arranged and given to patient? **Yes** ☐ **No** ☐

Medical factors (tick any)

☐ known HIV +ve (HAART Yes☐ No☐)
☐ offered HIV test (Audit A)
☐ not offered HIV test

☐ Hepatitis B +ve (test this episode Yes☐ No☐)
☐ Hepatitis C +ve (test this episode Yes☐ No☐)
☐ TNF-alpha treatment planned

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☐	refused HIV test	☐	TNF-alpha treatment planned
☐	tested HIV negative this Rx episode	☐	Diabetes
☐	tested HIV positive this Rx episode	☐	Long-term corticosteroid therapy
☐	chronic liver disease	☐	Low BMI (<20 =1, <18.5=2)
☐	chronic renal failure / haemodialysis	☐	Pregnant / postpartum at time of diagnosis
☐	opiate dependency	☐	Possible drug interactions
☐	alcohol dependency	☐	Drug Allergies
☐		☐	Other prescribed/ non prescribed medication

Name: Hospital no.

Psychosocial assessment:		**Agencies known to/ referred to:**
Housing (current situation)	☐ Urgent housing problem (NFA) give details ☐ Housing problem(no immediate action) give details ☐ No housing problem	Housing officer:
Immigration concerns	**Yes** ☐ **No** ☐ details	Immigration support worker:
History of imprisonment in past 5 yrs	**Yes** ☐ **No** ☐ details	Probation officer:
Substance misuse	Is the client scripted for methadone **Yes** ☐ **No** ☐ details Alcohol **Yes** ☐ **No** ☐ details Illicit drug **Yes** ☐ **No** ☐ details	Drug / alcohol worker:
Mental health	Give details including diagnosis	CPN/ CMHT
Communication	Needs interpreter **Yes** ☐ **No** ☐ Language: Sensory impairment **Yes** ☐ **No** ☐	
Financial (income/ benefits)	Nil income ☐ On benefits ☐ Other(SS/NASS) ☐ Employed ☐	
Mobility problem	**Yes** ☐ **No** ☐	
Access & Transport	Needs help with transport **Yes** ☐ **No** ☐ If yes : **Provision** ☐ **Finance** ☐	
Directly Observed Therapy (DOT)	offered **Yes** ☐ **No** ☐ if **No, reason**_____ if **Refused, reason** _____	
Other info: health beliefs, history of non-adherence (any medical treatment) lack of social/ family support or any other complicating factors		

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Any other places of regular contact (social services, probation services, drop-in centres, church groups, mosque, temple, etc)

Treatment delivery & support (at Rx start)

- ☐ DOT offered
- ☐ DOT refused
- ☐ DOT not poss.

- ☐ DOT (Clinic)
- ☐ DOT (Community)
- ☐ DOT other

Commence DOT form.

- ☐ Dossette box
- ☐ Self Admin (SAT) (weekly review)
- ☐ Self Admin (SAT) (monthly review)
- ☐ Self Admin (SAT) other (detail PTO)

Audit

F Offered HIV test (all >16 not already known +ve) **Yes** ☐ **No** ☐

G Assessed for risk of drug resistance **Yes** ☐ **No** ☐

H DOT from onset if at risk **Yes** ☐ **No** ☐

Initial assessment by (Name): _____ **Date:** _____

Signature: _____ **Designation:** _____

Lone worker visit assessment done

Yes ☐ **No** ☐ date: / /

Home/ community assessment done

Yes ☐ **No** ☐ date: / /

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Continuation Sheet : Name:		Hospital number:
Date/time	**Notes:**	**Signature:**

Source:
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