Royal College of Nursing

# TB patient review record (Form: 2a)

## Form 2a: TB patient review record. Clinic:

| NHS no. | Hospital No: | Case manager: | Consultant: | |
|---|---|---|---|---|
| Last name: | Other names: | LTBR / ETS no: | Diagnosis: | |
| DOB: / / Treatment start date: / / | Estimated date change to dual therapy : / / | Weeks on TB/LTBI treatment: | Estimated treatment completion date: / / | |

Nurse OPA ☐ Case worker OPA ☐ Medical OPA ☐ | Venue: OPD/Ward ☐ Home visit ☐ | **Date next follow-up:** / /

**Interpreter used** **No** ☐ **Yes** ☐ Language: ID code:

### Symptoms & Progress

Appetite, weight loss, fever, coughing, night sweats, lethargy, feeling better: Request sputum **No** ☐ **Yes** ☐

Side effects: (nausea/vomiting, rash, itchy skin, joint pain)

Weight: Kg **Increase** ☐ **Decrease** ☐

Liver function test: Previous: / / **Normal** ☐ **Abnormal** ☐

Checked today : **Yes** ☐ **No, not due/ indicated** ☐

Visual disturbances (Ethambutol) **N/a** ☐ **No** ☐ **Yes** ☐ **If yes, has vision screen been undertaken?** ☐ Comments (if applicable):

**Medication:** Self Administered: **No** ☐ **Yes** ☐ DOT : **No** ☐ **Yes** ☐

**Frequency:** Daily ☐ 3 x weekly ☐

### Adherence

**Self reported:** Doses missed? **No** ☐ **Yes** ☐ If yes, No. of doses missed: _____ More than 85% of doses taken? **Yes** ☐ **No** ☐

Percentage of doses taken: _____ Reason for non-adherence: _____

_____

Tablet identification: **Correct** ☐ **Incorrect** ☐ Tablet count: **Correct** ☐ **Incorrect** ☐ **Did not bring** ☐

Butanol/other urine test in use **N/a** ☐ **Positive** ☐ **Negative** ☐ **Not done** ☐ (state reason) _____

| **Adherence Plan:** | Continue/ resume Self Admin Therapy (SAT) **Yes** ☐ **No** ☐ | DOT offered : **Yes** ☐ **No** ☐ | Switched to DOT: **No** ☐ (Please comment overleaf) **Yes** ☐ Date: / / (initiate Form 4/5 DOT Form) |
|---|---|---|---|

**Recommended BBV screening:** HIV outcome documented ☐ Hepatitis outcome documented ☐ Rpt. offered required? **Yes** ☐ **No** ☐

**Prescription:** Repeated on time ☐ Repeated late ☐ comment:

**TB Medication:**

Length of supply given: (in days)

Due date next prescription: / /

| | | |
|---|---|---|
| Px *Rifinah:* _____ | Px *Ethambutol:* _____ | Px *Vit D:* _____ |
| Px *Rifampicin:* _____ | Px *Pyrazinamide:* _____ | Px *Other:* _____ |
| Px *Isoniazid:* _____ | Px *Pyridoxine :* _____ | Px *Other:* _____ |
| Px *Rifater :* _____ | Px *Rifabutin:* _____ | Px *Other:* _____ |

**Other medication (Non-/Prescribed)**

| | | |
|---|---|---|
| Px _____ | Px _____ | Px _____ |
| Px _____ | Px _____ | Px _____ |
| Px _____ | Px _____ | Px _____ |

## TB patient review record (Form: 2a)

| | | | |
|---|---|---|---|
| If any new medication since last visit, drug interactions/contra-indications discussed: N/a ☐ Yes ☐ Comment: | | | |
| Women of childbearing age reminded regarding reduced efficacy of oral/implant contraception by taking *Rifampicin*? **Yes** ☐ **N/a** ☐ | | | |
| **Contact tracing:** | **Complete** ☐ **Incomplete** ☐ New contacts identified **No** ☐ **Yes** ☐ comments (incl. date referred): | | |
| Assessment date | Assessor ; Name: | Designation: | Signature |

| **Name** | **Hospital no.** |
|---|---|

**Form 2: Notes relevant to follow-up. *including update on medical factors/psychosocial assessment recorded on Form2**

| **Date/time** | **Comments/ Actions:** | **Signature/ Designation:** |
|---|---|---|
| | | |

Source:
Pam Tsangarides, Hillingdon Hospital NHS Foundation Trust and Find and Treat Team, University College London Hospitals