##  NEW MEXICO DEPARTMENT OF HEALTH

## Treatment for Latent Tuberculosis Infection Monthly Monitoring Flow Sheet

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| **Name (Last, First, MI):**  | **Birth Date:** |
| **Medication Orders:** |
| **Physician:**  | **Additional orders (labs/x-ray/other)** |
| **Medication Start Date:** | **Anticipated completion Date** |
| **Date: (weekly/monthly)** |  |  |  |  |  |  |  |  |  |  |  |  |
| TB symptoms? (i.e., persistent cough, bloody sputum, weight loss, fever, night sweats, etc).  |  |  |  |  |  |  |  |  |  |  |  |  |
| ADVERSE DRUG EVENTS |  |  |
| Loss of appetite (all) |  |  |  |  |  |  |  |  |  |  |  |  |
| RUQ abdominal discomfort (all) |  |  |  |  |  |  |  |  |  |  |  |  |
| Unusual/Excessive fatigue (all)  |  |  |  |  |  |  |  |  |  |  |  |  |
| Nausea/Vomiting (all) |  |  |  |  |  |  |  |  |  |  |  |  |
| Unexplained fever > 3 days (all) |  |  |  |  |  |  |  |  |  |  |  |  |
| Urine color change (dark) (all) |  |  |  |  |  |  |  |  |  |  |  |  |
| Stool color change (light) (all) |  |  |  |  |  |  |  |  |  |  |  |  |
| Jaundice (yellow skin/eyes) (all) |  |  |  |  |  |  |  |  |  |  |  |  |
| Skin rashes/Itching (all) |  |  |  |  |  |  |  |  |  |  |  |  |
| Numbness/Tingling in arms/legs (INH) |  |  |  |  |  |  |  |  |  |  |  |  |
| Flu-like symptoms (RPT/RIF) |  |  |  |  |  |  |  |  |  |  |  |  |
| Unusual bleeding/bruising (RPT/RIF) |  |  |  |  |  |  |  |  |  |  |  |  |
| Change in urine output (RPT/RIF) |  |  |  |  |  |  |  |  |  |  |  |  |
| TEACHING |  |  |
| Common adverse drug events; STOP medication and notify Nurse adverse drug events occur |  |  |  |  |  |  |  |  |  |  |  |  |
| Signs/Symptoms of TB disease |  |  |  |  |  |  |  |  |  |  |  |  |
| Avoiding alcohol use and exposure to other hepatotoxins |  |  |  |  |  |  |  |  |  |  |  |  |
| Orange discoloration of body fluids (RIF/RPT) |  |  |  |  |  |  |  |  |  |  |  |  |
| Date of LMP: Effect on hormonal contraceptives (RPT) |  |  |  |  |  |  |  |  |  |  |  |  |
| Adherence; importance of treatment completion |  |  |  |  |  |  |  |  |  |  |  |  |
|  **Adherence with Treatment** |  |
| **Medication Dispensed/amount** |  |  |  |  |  |  |  |  |  |  |  |  |
| \*\*\*\* # of doses missed  |  |  |  |  |  |  |  |  |  |  |  |  |
| \*\*\*\* # doses taken this month |  |  |  |  |  |  |  |  |  |  |  |  |
| **Health care provider’s initials:** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Client’s initials:**  |  |  |  |  |  |  |  |  |  |  |  |  |

**\*\*\*\* for use when dispensing doses for home administration not for DOT dosing**

##### Y = Yes N = No N/A = Not Applicable C = See chart note INH = Isoniazid RPT = Rifapentine RIF = Rifampin

**CLIENT/DOT PROVIDER AGREEMENT:**

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| --- |
| **We agree to meet at (location) on day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****at (time) AM / PM for DOT medication, unless alternate arrangements are made in advance by either party.****Client’s signature/ initials: \_\_ DOT Provider signature/initials: \_\_\_\_\_\_\_\_\_\_\_\_****Nurse case manager’s signature/initials: Interpreter signature/ initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Complete when closing case: Total # DOSES ingested: \_\_\_\_\_\_\_\_\_\_ Total # WEEKS on therapy: \_\_\_\_\_\_\_\_\_\_ Completed therapy: Yes NoNote: Completion of treatment: 3HP = 11 or 12 doses must be given within 16 weeks. Each dose must be separated by >72 hours. INH 9 months = 270 doses Rifampin 4 months = 120 INH + Rifampin = 90 See TBI Protocol for more details on dose completion calculation  |

#### TB 004/TBI LTBI Monitoring Flow Sheet 03/2020