

TUBERCULOSIS FLOW SHEET

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|------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------|---------------------------|------------------------------|------------------------------|
| Name: | | Date of Birth: | | Gender at birth: Male Female | |
| Case/Suspect | Initial Treatment: 4 Drug Regimen - Option 1 | | 4 Drug Regimen - Option 2 | | Other |
| LTBI/Presumptive LTBI | Initial Treatment: Isoniazid 9 mo. | | Rifampin 4 mo. | Rifampin 6 mo. | Isoniazid/Rifapentine 12 wk. |
| Med Start Date: | <input type="checkbox"/> DOT <input type="checkbox"/> Non- DOT | | Contact | MDR | Ryan White |
| Isolation Ordered <input type="checkbox"/> YES <input type="checkbox"/> NO | Isolation Stop Date: | Last Date Worked: | | Date Returned to Work: | |
| Telephone Nurse Monitoring Program | | Start Date: | | | |
| KEY: YES = √ NO = ∅ NORMAL = N ABNORMAL = ABN (Make note) NOT ASSESSED = NA POSITIVE = POS NEGATIVE = NEG | | | | | |
| Date | | | | | |
| Adheres to treatment plan /Number of doses completed to date | | | | | |
| # missed doses/# missed appointments (make note) | | | | | |
| Last menstrual period | | | | | |
| Alcohol Use/Substance Use (make note) | | | | | |
| Any travel since last visit? Plans to travel within the next month? | | | | | |
| Review of Systems (Questions on back of flow sheet) | | | | | |
| CONSTITUTIONAL | | | | | |
| HEENT | | | | | |
| SKIN | | | | | |
| CARDIOVASCULAR | | | | | |
| RESPIRATORY | | | | | |
| GASTROINTESTINAL/GENITOURINARY | | | | | |
| NEUROLOGICAL | | | | | |
| MUSCULOSKELETAL | | | | | |
| Physical Evaluation | | | | | |
| VITAL SIGNS: Temperature/Pulse/Respirations | | | | | |
| Blood Pressure | | | | | |
| Current weight (Initial weight at diagnosis _____) | | | | | |
| HEENT | | | | | |
| Vision acuity test/Vision color discrimination | | | | | |
| SKIN | | | | | |
| Rash (trunk = t, back = b, extremities = e) | | | | | |
| Bruises (trunk = t, back = b, extremities = e) | | | | | |
| RESPIRATORY | | | | | |
| Shortness of Breath | | | | | |
| Cough (note characteristics) | | | | | |
| GASTROINTESTINAL | | | | | |
| Abdominal tenderness | | | | | |
| NEUROLOGICAL | | | | | |
| Memory loss/poor cognition/dizziness | | | | | |
| MUSCULOSKELETAL | | | | | |
| Pain, swelling of joints/abnormal gait | | | | | |
| Laboratory Tests Ordered | | | | | |
| Baseline Hepatitis B/Hepatitis C/HIV | | | | | |
| Glucose/Hbg A1C | | | | | |
| Uric Acid/Serum Creatinine/Bilirubin | | | | | |
| AST/ALT/Liver Profile | | | | | |
| CBC with differential | | | | | |
| Pregnancy test (if applicable) | | | | | |
| Most recent date of sputum specimen | | | | | |
| Most recent sputum status (Positive, Negative, NA) | | | | | |
| Medications Ordered and Dispensed | | | | | |
| Isoniazid _____ mg _____ tab(s) PO _____ x wk X _____ mo # _____ (# doses _____) | | | | | |
| Rifampin _____ mg _____ cap(s) PO _____ x wk X _____ mo # _____ (# doses _____) | | | | | |
| Pyrazinamide _____ mg _____ tab(s) PO _____ x wk X _____ mo # _____ (# doses _____) | | | | | |
| Ethambutol _____ mg _____ tab(s) PO _____ x wk X _____ mo # _____ (# doses _____) | | | | | |
| Pyridoxine _____ mg _____ tab(s) PO _____ x wk X _____ mo # _____ (# doses _____) | | | | | |
| Rifapentine _____ mg _____ tab(s) PO _____ x wk X _____ mo # _____ (#doses _____) | | | | | |
| | | | | | |
| | | | | | |
| Next appointment date | | | | | |
| Nurse's Signature | | | | | |

REFERENCE: Review of Systems questions:

CONSTITUTIONAL: Does the patient have any unexplained weight loss, fever, chills, weakness or fatigue, night sweats, and/or loss of appetite? How severe are they?

HEENT: Does the patient have any vision loss, blurred vision, double vision or trouble distinguishing colors? Does he/she wear glasses?

Does the patient have any hearing loss or ringing in the ears? Does he/she wear a hearing aid?

SKIN: What is the normal color of skin? Are there any rashes or itching? If so, what is the cause? Is there any bruising? Does the patient bruise easily?

CARDIOVASCULAR: Does the patient have any chest pain, chest pressure/chest discomfort, palpitations or edema?

RESPIRATORY: Is the patient experiencing any shortness of breath, cough or sputum? Is this something new or is this a chronic condition? Is the patient coughing up blood?

GASTROINTESTINAL/GENITOURINARY: Does the patient have anorexia, heartburn, nausea, vomiting or diarrhea or abdominal pain? Does anything relieve it? Does anything precipitate it? What color are his/her stools? Is there any blood in the stool? What color is the patient's normal urine? Does he/she have bladder or kidney infections? Have they ever had a problem with kidney function?

NEUROLOGICAL: Does the patient have headaches? What kind and what relieves them? Does he/she have dizziness, syncope, paralysis, ataxia, numbness or tingling in the extremities? Is there any problem with memory or cognition?

MUSCULOSKELETAL: Does the patient have muscle and/or back pain? Does he/she have any arthritis, joint pain or stiffness? Is there any weakness in his/her limbs or any problem with gait and movement? Have they ever had signs of gout?