Georgia Department of Public Health

Tuberculosis Flowsheet

Name:	Date of Birth:

Reason for Treatment: case suspect LTBI therapy

Denies = Ø Complaint = + Non-applicable = N/A	Date:	Date:	Date:	Date:	Date:	Date:
PATIENT HISTORY						
Productive Cough / Hemoptysis / Chest pain						
Fever/Chills / Night Sweats						
Loss of Appetite / Weight Loss / Nausea/Vomiting						
Skin Rash / Dizziness / Unsteady Gait / Weakness						
Abdominal Pain / Jaundice / Dark Urine						
Tingling / Joint Pain / Bleeding problems						
Fatigue / Fever/Flu-like Symptoms						
Visual Problems / Change in Hearing / Development of new allergies						
Birth Control Method/LMP						
Alcohol/Drug use (Type_____ Frequency_____)						
Compliant with therapy / Behavioral Changes						
CLINICAL EVALUATION						
Weight (Height_____)						
Blood Pressure						
AST/SGOT/Liver Profile						
CBC/Chemistry						
HIV/Hepatitis						
Pregnancy Test						
Visual Acuity/Red /Green Discrimination						
Hearing Exam						
BACTERIOLOGY						
Sputum Smear/Culture						
Other Specimen (Type) Smear/Culture						
Sensitivity						
MEDICATIONS - DOT/DOPT/SA						
Isoniazid____ mg ___tab PO ___x wk X___ mo #____ (# doses____)						
Rifampin____ mg ___cap PO ___x wk X___ mo #____ (# doses____)						
Pyrazinomide____ mg __tab PO __x wk X___ mo #____ (# doses____)						
Ethambutol____ mg ___tab PO ___x wk X___ mo #____ (# doses____)						
Pyridoxine__ mg ___tab PO ___x wk X___ mo #____ (# doses____)						
CODE APPROPRIATELY: Ordered by MD (MD) / Nurse (N) Dispensed by RPH (RPH) / Nurse (N)						
EDUCATION						
TB Disease						
TB Infection						
Medications / Side Effects						
Substance Abuse						
HIV Risk Assessment						
REFERRALS						
Specify Referral (Chest x-ray, Physician, Nutritionist, Social Services, Epi, etc.)						
Next Clinic Appointment						
Nurse Signature						