



TUBERCULOSIS (TB) TREATMENT OUTCOMES REPORT FORM

First Nations and Inuit Health Branch – Ontario Region

Date Treatment form completed: DD-____-____ YYYY-____-____

Date faxed to CD nurse: DD-____-____ YYYY-____-____

Case Number: _____

Initials and date (DD/MMM/YYYY) each time form is updated and re-faxed to CD nurse: _____

Client Verification

Date of Birth: DD-____-____ MMM-____-____ YYYY-____-____

Gender: ☐ Male ☐ Female

Age: _____

☐ Other (specify): _____

Date of Diagnosis: DD-____-____ MMM-____-____ YYYY-____-____

Date treatment started: DD-____-____ MMM-____-____ YYYY-____-____

Last day of treatment: DD-____-____ MMM-____-____ YYYY-____-____

If applicable, date discharged from hospital: DD-____-____ MMM-____-____ YYYY-____-____

Was active TB ruled out? ☐ Yes ☐ No ☐ Not applicable (i.e. active TB confirmed on initial notification)



☐ Clinical ☐ Lab confirmed

Date of negative culture: DD-____-____ MMM-____-____ YYYY-____-____

Alternate diagnosis, if known: _____

If Yes, skip sections below and submit this form. If No, complete the remaining sections below.

Treatment

Resistance developed during treatment (check all that apply)? ☐ Yes ☐ No ☐ Not tested ☐ Unknown ☐ No drugs prescribed



☐ INH ☐ RMP ☐ Streptomycin ☐ Rifabutin ☐ Ethionamide ☐ PAS ☐ Other (specify): _____

☐ EMB ☐ PZA ☐ Kanamycin ☐ Ofloxacin ☐ Capreomycin ☐ Vit B₆ _____

Treatment regime - drugs taken >1 month (check all that apply)? ☐ Yes ☐ No Drugs Prescribed ☐ Unknown



☐ INH ☐ RMP ☐ Streptomycin ☐ Rifabutin ☐ Ethionamide ☐ PAS ☐ Other (specify): _____

☐ EMB ☐ PZA ☐ Kanamycin ☐ Ofloxacin ☐ Capreomycin ☐ Vit B₆ _____

Major mode of treatment:

☐ DOT (Directly Observed Therapy) → ☐ Modified ☐ Standard ☐ Enhanced (See definitions in Guidelines for TB Report Forms)

☐ Daily, self-administered

☐ Other (specify): _____

☐ Unknown

Adherence estimate (% of medication received):

☐ 80% + ☐ 50 – 79% ☐ <50% ☐ Unknown

Treatment Outcomes

Negative cultures since treatment was initiated: ☐ Yes ☐ No ☐ Unknown ☐ Not available



First negative culture since treatment was initiated: DD-____-____ MMM-____-____ YYYY-____-____

First negative culture after treatment completion: DD-____-____ MMM-____-____ YYYY-____-____

Indicate the treatment outcome (check one only):

☐ Cure – negative culture at completion of treatment

☐ Treatment completed – without culture at end of treatment

☐ Failure – continued or recurrent positive culture after 4 months or more of treatment

☐ Death during treatment → Date of death: DD-____-____ MMM-____-____ YYYY-____-____

☐ TB was the cause of death

☐ TB contributed to the death, but was not the underlying cause

☐ TB did not contribute to death

☐ Treatment ongoing

☐ Treatment outcome unknown – client moved off reserve (Specify new location: _____)

☐ Treatment outcome unknown for other reason (Specify reason: _____)

☐ Other (specify): _____

Nurse Identification

First Name: _____

Last Name: _____

Signature: _____