

Case Management Treatment Plan for Active TB Disease

The purpose of this form is to provide a checklist to organize the gathering of information in a TB case to ensure the best medical and public health practices. Corresponding TB forms, both required and recommended, are listed with each component. (* denotes forms that are required by the state of Montana)

Patient Name _____ Date _____

___ Patient's contact information – 1. Confirmed/Suspected Report of TB Disease*
2. TB Case Monthly Report*

___ Assignment of responsibilities – 1. Confirmed/Suspected Report of TB Disease*
2. TB Case Monthly Report*
3. TB Contact Investigation Report*
4. DOT - Treatment Record
5. TB Diagnostic Referral Form

___ Patient educator's name & dates of education – 1. Monthly TB Patient Assessment
2. Treatment of Active TB Education Form

___ Method for prevention of transmission – 1. Home Isolation Agreement

___ Planned course of antituberculosis drug therapy – 1. Confirmed/Suspected Report of TB Disease*
DOT plan 2. TB Case Monthly Report*
3. DOT - Treatment Record
4. DOT Agreement

___ Estimated date of completion of treatment - 1. Confirmed/Suspected Report of TB Disease*
2. TB Case Monthly Report*
3. DOT - Treatment Record

___ Test results from initial medical evaluation – 1. Confirmed/Suspected Report of TB Disease*

___ Medical history – 1. Confirmed/Suspected Report of TB Disease*
2. TB Case Monthly Report*
3. Monthly TB Patient Assessment

- ___ Diagnosis – 1. Confirmed/Suspected Report of TB Disease*
 - 2. TB Diagnostic Referral Form
 - 3. Bacteriology Data Sheet

- ___ Baseline tests, monitoring of activities, – 1. Confirmed/Suspected Report of TB Disease*
 - Drug therapy & side effects
 - 2. TB Case Monthly Report*
 - 3. Monthly TB Patient Assessment
 - 4. DOT - Treatment Record
 - 5. DOT - Adverse Reactions & Side Effects
 - 6. Bacteriology Data Sheet
 - 7. Biochemistry Data Sheet

- ___ Potential drug interactions - 1. TB Case Monthly Report*
 - 2. Monthly TB Patient Assessment
 - 3. DOT - Treatment Record
 - 4. DOT - Adverse Reactions & Side Effects

- ___ Potential treatment adherence obstacles - 1. TB Case Monthly Report*
 - 2. Monthly TB Patient Assessment
 - 3. DOT - Treatment Record
 - 4. TB Home Evaluation
 - 5. Treatment Active TB Education Form

- ___ Personal service needs & social services referrals – 1. Monthly TB Patient Assessment
 - 2. TB Home Evaluation

- ___ Referrals for social services - 1. Monthly TB Patient Assessment
 - 2. TB Home Evaluation

- ___ Ensuring completion of treatment – 1. DOT - Agreement
 - Incentives, enablers, adherence
 - 2. DOT - Treatment Record
 - 3. Monthly TB Patient Assessment
 - 4. Treatment of Active TB Education Form

- ___ Intermediate & expected outcomes – 1. TB Case Monthly Report*
 - Sputum & culture conversion
 - 2. Monthly TB Patient Assessment
 - Symptom improvement
 - 3. DOT Agreement

TB DISEASE MONTHLY PATIENT ASSESSMENT

Name: _____ **DOB:** _____ **Date of Visit:** _____ **Interpreter:** _____
Location of visit: Home ___ Office ___ Other _____
Case conference last done on: _____
Type of TB: Pulm. TB Y / N **Date Of Last CXR:** _____
 Extra-pulm. TB Y / N **Site:** _____ **Improved:** _____
 Currently infectious Y / N **Stable:** _____ **Worse:** _____

<u>Other Medical Conditions</u>	<u>Medications / Changes</u>	<u>Education</u>
None Asthma COPD ESRD Hep C / Hep B Liver Other: _____ Tobacco use Y / N Cessation Counseling Y / N	Anti-coagulants Anti-hypertensives Coumadin HIV meds Immunosuppressives Insulin Oral Hypo-glycemics Other: _____	DX, Infection Vs. Disease _____ Transmission/Prevention _____ Meds: Resistance/Side Effects _____ General health care _____ HIV/AIDS information Counseling & testing _____ TB & HIV _____ Diagnostic Procedures _____ Community Resources _____ Other: _____

<u>Assessment</u>	<u>Reactions to Meds</u>	<u>Psychosocial</u>
Weight: _____ B/P: _____ Pulse Oximetry : _____ % LMP: _____ AFB: Sputum ___ Urine ___ Other _____ Last date submitted: _____ Due: _____ Containers given for (date): _____ Problems: _____ Lab work drawn: HFP CMP Y / N CBC Y / N Other: _____ Vision check: Distance: Rt. ___ L. ___ Both: _____ Glasses: Y / N Color vision all plates seen: Y / N Problems: _____ Hearing screening: Y / N Results: _____ Balance: WNL ABN	Hepatotoxicity INH, RIF, EMB, PZA Jaundice Y / N Fever Y / N Nausea Y / N Light stools Y / N Vomiting Y / N Dark urine Y / N Abd. Y / N Hypersensitivity INH, RIF, EMB, PZA Rash Y / N Arthralgia Y / N Non specific INH, RIF, EMB, PZA Headache Y / N Malaise Y / N Fatigue Y / N Anorexia Y / N Neurotoxicity INH, EMB Paresthesia Y / N Dizziness Y / N Visual changes Y / N Distance Y / N Hemolytic RIF Bruising increase Y / N Bleeding gums Y / N Hematuria Y / N Hematochezia Y / N	Alcohol / Drug use _____ Behavioral / Mental Health _____ Homeless _____ Language barrier _____ Cultural barrier _____ Limited cognitive skills _____ Transportation _____ Long work hours _____ No insurance _____ Inadequate food/income _____ DOT # Missed doses in past month _____ Problems: _____ _____ _____ _____ Referrals: _____ _____ _____ _____

Nurses' Comments:

Re-interviewed for more **contacts** Y / N **Comments:** _____
 PHN Signature: _____ **Date:** _____

MONTHLY TUBERCULOSIS CASE REPORT
Submit 1st day of every month- new information from last report only

Department of Public Health & Human Services
 TB Program
 Cogswell Building, Room C-216
 1400 Broadway, Helena, MT 59620
 Phone: 406-444-0275; Fax: 406-444-0272

Today's Date: _____

Submitted By: _____

Agency: _____

Phone: _____

This Report is being submitted for: Month _____ Year _____

Patient Name: _____

City: _____ County: _____

Diagnostic Update:

Sputum Conversion: Collect until 3 consecutive negative results

Test	Date Collected	Result	Test	Date Collected	Result
AFB Smear			M.tuberculosis Culture		
AFB Smear			M.tuberculosis Culture		
AFB Smear			M.tuberculosis Culture		
AFB Smear			M.tuberculosis Culture		
AFB Smear			M.tuberculosis Culture		

X-Ray: Date: _____ Result: _____

HIV: Date: _____ Result: _____

Other Tests: _____ Date: _____ Result: _____

Most Recent Medical Exam: Date: _____ Result: _____

Symptoms: () Cough () Productive cough () Fever () Night Sweats
 () Chest Pain () Weight Loss () Other, specify: _____

Hospitalization: Date: _____ Admitting Diagnosis: _____

Medication - Treatment and Adherence:

DOT Plan (describe) _____

Self-Administration: _____

Breaks in Therapy: (give specific date, doses, reason) _____

List medication side effects: _____

Medication	Dose	Date Started	Projected Length of Therapy	Date Treatment Completed	Date Meds Dc'd and reason e.g. side effects, resistance, moved
Isoniazid -INH					
Rifampin - RIF					
Pyrazinamide - PZA					
Ethambutol - EMB					
Other:					

Therapy Completed & Case Closed: _____ (This will be the final report)

LTBI MONTHLY PATIENT ASSESSMENT (LATENT TB INFECTION)

Name: _____ DOB: _____ Date of Visit: _____ Interpreter: _____
 Location of visit: Home ___ Office ___ Other _____
 Case conference last done on: _____

Other Medical Conditions

None
 Asthma _____ Cancer _____
 COPD _____ Diabetes _____
 ESRD _____ GI _____
 Hep C / Hep B _____ HTN _____
 Liver _____ Pregnant _____
 Other: _____

Tobacco use Y / N
 Cessation Counseling Y / N

Medications / Changes

Anti-coagulants
 Anti-hypertensives
 HIV meds
 Immunosuppressives
 Insulin
 Oral Hypo-glycemics

Other: _____

Education

DX, Infection Vs. Disease _____
 Meds: Resistance/Side Effects _____
 General health care _____
 HIV/AIDS information
 Counseling & testing _____
 TB & HIV _____
 Diagnostic Procedures _____
 Community Resources _____
 Other: _____

Assessment

Weight: _____ B/P: _____

Pulse Oximetry : _____ % LMP: _____

Other: _____

Chest X-ray: date _____

Lab work drawn:

HFP
 CMP Y / N
 CBC Y / N
 Other: _____

Reactions to Meds

Hepatotoxicity INH, RIF, EMB, PZA

Icterus Y / N
 Fever Y / N
 Nausea Y / N
 Light stools Y / N
 Vomiting Y / N
 Dark urine Y / N
 Abd. Y / N

Hypersensitivity INH, RIF, EMB, PZA

Rash Y / N
 Arthralgia Y / N

Non specific INH, RIF, EMB, PZA

Headache Y / N
 Malaise Y / N
 Fatigue Y / N
 Anorexia Y / N

Neurotoxicity INH , EMB

Paresthesia Y / N
 Dizziness Y / N
 Visual changes Y / N
 Distance Y / N

Hemolytic RIF

Bruising increase Y / N
 Bleeding gums Y / N
 Hematuria Y / N
 Hematochezia Y / N

Psychosocial

Alcohol / Drug use _____
 Behavioral / Mental Health _____
 Homeless _____
 Language barrier _____
 Cultural barrier _____
 Limited cognitive skills _____
 Transportation _____
 Long work hours _____
 No insurance _____
 Inadequate food/income _____

DOT

Missed doses in past month _____

Problems: _____

Referrals:

Nurses' Comments:

PHN Signature: _____

Date: _____

TB Case Management Monitoring Record

(4/2003 sample)

Case name: _____ DOB _____ Rec # _____

LHD or PMD _____ Phone _____ Fax _____

Diagnostic Evaluation: Symptoms (circle all) Date cough started: _____

Cough, Sputum: thick/thin, color: _____, Hemoptysis, Fever, Night Sweats, Malaise, Wt. Loss of _____ lbs

Diagnostic Microbiology:

	Date of spec	Type of spec	AFB smear	AFB culture	Susceptibilities	
1.	_____	_____	_____	_____	_____	TST: Date: _____ _____ MM <input type="radio"/> Not done
2.	_____	_____	_____	_____	_____	
3.	_____	_____	_____	_____	_____	

CXR⁶: _____

TREATMENT PLAN: 6 MONTH OTHER: _____

	Pt. Wt. =	Start Month	(# months of treatment → NOTE: regimen & total # of doses determines when completes treatment)								
			1 st month	2 nd month ^s	3 rd month	4 th month	5 th month	6 th month	7 th month	8 th month	9 th month
INH	_____ mg	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
RIF	_____ mg	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
PZA	_____ mg	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
EMB	_____ mg	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
B6	_____ mg	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
	_____ mg	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
	_____ mg	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

DOT doses: _____
 (Initial phase doses / Continuation phase doses [pt should receive all initial phase doses first])
Self Administered (Standard of care is to be on DOT: only extremely rare circumstances would justify self administered)
 # doses injected/mo _____

MONTHLY MONITOR:

Side effects ¹	_____	_____	_____	_____	_____	_____	_____	_____	_____
Isolation ² Yes/ n/a	_____	_____	_____	_____	_____	_____	_____	_____	_____
Smear status ³ above	_____	_____	_____	_____	_____	_____	_____	_____	_____
Culture status ⁴ above	_____	_____	_____	_____	_____	_____	_____	_____	_____
Clinical Resp ⁵	_____	_____	_____	_____	_____	_____	_____	_____	_____
Chest X-ray ⁶3mo prn	End of tx						
MD/clinical Evaluation	_____	_____	_____	_____	_____	_____	_____	_____	_____

¹ Side effects: Ø = none noted, **P** = problem: see progress notes (symptom review, labs as ordered, visual/color while on EMB)
² Sputum smear positive cases should be isolated until non-infectiousness is established by: demonstrate a good clinical response to treatment, AND have been on adequate TB treatment for 2 weeks, AND have 3 consecutively negative sputum smears for AFB.
³ Pulmonary cases: collect at least one monthly to document conversion to negative smear, then collect 2nd & 3rd to document non-infectiousness and release from isolation. Frequency of collection depends on severity of illness and diagnostic sputum smears.
⁴ Pulmonary cases: collect one monthly to document conversion to negative cultures
⁵ Clinical response: list letter code for persistent symptoms (eg/ C for cough), improved, or resolved. AFTER 2nd mo., eval the regimen.
⁶ Initial: **C**=cavitary, **N**=Non-Cavitary:infiltrates, scarring, nodules, etc / prn=improved, stable, worse / End= improved, stable, worse

Client Name: _____ **DOB** _____ **Address:** _____ **Phone:** _____ **I.D.** _____

Clinical Path - Dx.: Positive PPD Physician: _____

KEY

D = Demonstrates X = Done
 U = Understands I = Instruct/Reinstruct
 C = Complies VR = Variance
 0 = None N/A = Not Applicable
 N/C=No Change / = Did Not Assess

Signature	Initials

OUTCOMES/GOALS:

DATE MET:

- Client or caregiver will understand disease process and screening procedures

- Client or caregiver will verbalize understanding of significant occurrences and when to call health care provider

- Client or caregiver will follow-up with recommended medical care within () days of nursing visit

- Client or caregiver will verbalize understanding of possible complications if follow-up not obtained

- Client or caregiver will leave with all questions relating to condition answered

- Client or caregiver will verbalize understanding of importance of finishing treatment

Date	Initials					Nurse's Evaluation and Progress Notes
DIRECT CARE						
Assess vital signs						
<input type="checkbox"/> BP						
<input type="checkbox"/> Pulse						
<input type="checkbox"/> Respirations						
<input type="checkbox"/> Temperature						
Allergies:						
Screening tests completed/Results:						
<input type="checkbox"/> PPD results _____ mm Date: _____						
<input type="checkbox"/> Chest x-ray						
<input type="checkbox"/> Liver function						
<input type="checkbox"/> Visual Acuity						
<input type="checkbox"/> Sputum culture/gram stain/sensitivity						
Assess risk factors:						
<input type="checkbox"/> Medical conditions, including HIV						
<input type="checkbox"/> Living arrangements/Low income						
<input type="checkbox"/> Contact with people with active TB						
<input type="checkbox"/> Immigrants						
<input type="checkbox"/> Illicit drug use						
<input type="checkbox"/> Elderly or child < 4 years						
<input type="checkbox"/> Occupational exposure						
Assess relevant psych/social dimensions:						
<input type="checkbox"/> Insurance/income to cover screening & treatment						
<input type="checkbox"/> Able/willing to comply with treatment						
Assess for s/ s of medication side effects:						
<input type="checkbox"/> Loss of appetite						
<input type="checkbox"/> Dark colored urine						
<input type="checkbox"/> Jaundice						
<input type="checkbox"/> Rash/itching						
<input type="checkbox"/> Blurred vision						

Medication side effects (cont):	Date					Nurses' Evaluation and Progress Notes
<input type="checkbox"/> Unusual pain in hands/feet/joints						
<input type="checkbox"/> Headache						
<input type="checkbox"/> Dizziness/Drowsiness						
<input type="checkbox"/> Nausea/Vomiting						
<input type="checkbox"/> Convulsions						
<input type="checkbox"/> General tiredness						
Assess for s/s of active TB:						
<input type="checkbox"/> Cough						
<input type="checkbox"/> Hemoptysis						
<input type="checkbox"/> Chest pain						
<input type="checkbox"/> Fatigue/malaise						
<input type="checkbox"/> Weight loss						
<input type="checkbox"/> Fever/night sweats						
INSTRUCTION AND INFORMATION						
Prevention recommendations:						
<input type="checkbox"/> Finish medications						
<input type="checkbox"/> Testing contacts						
<input type="checkbox"/> Vitamin B6						
<input type="checkbox"/> Future PPD/x-rays						
Educational materials discussed and given:						
<input type="checkbox"/> S/s of active TB						
<input type="checkbox"/> Medication sheets						
<input type="checkbox"/> Signs and symptoms of complications						
<input type="checkbox"/> Active vs latent TB						
<input type="checkbox"/>						
Referrals made to:						
<input type="checkbox"/> Physician						
<input type="checkbox"/> HIV testing						
<input type="checkbox"/>						
Follow-up appointment kept with/date:						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
Medications (list) and DOT (as applicable):						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
Confidentiality of Records per protocol						
Informed Consent per protocol						
Next PHN visit or follow-up call						

Tuberculosis (TB) Directly Observed Therapy Agreement

To: _____
Patient name

D.O.B.: _____

Because it is very important that you follow the doctor's orders so that you are cured of TB, you are being placed in a supervised treatment program by your physician and the County Health Department.

This program requires that you:

Take your TB medicine while being observed by the Public Health Nurse or other designated staff as indicated below (days, time, and location):

LOCATION: _____

DAYS: **Monday Tuesday Wednesday Thursday Friday** (circle 2 days if bi-weekly)

TIME: _____ a.m. / p.m.

We want to help you get better as quickly as possible and to protect those around you from getting TB. If you do not follow these directions for treatment, your condition could worsen and you could spread the disease to others. If you do not continue supervised treatment, the County may pursue legal action against you, which if convicted, may result in court ordered detainment for your treatment.

PHN or Designee Signature

Date

I have read the above information, understand it, and agree to the conditions.

Patient's Signature

Date

Interpreter Signature (*if needed*)

Date

Copy given to patient _____ (PHN or Designee Initials)

DIRECTLY OBSERVED THERAPY RECORD

Name of Patient: _____

Isolation Residence: _____

Date	Time	Medication Given		Comments (List any other meds given, and/or if contact was attempted and patient wasn't home)	Staff Signature
		<input type="checkbox"/> Isoniazid <input type="checkbox"/> Pyrazinamide <input type="checkbox"/> Pyridoxine (B ₆)	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ethambutol		
		<input type="checkbox"/> Isoniazid <input type="checkbox"/> Pyrazinamide <input type="checkbox"/> Pyridoxine (B ₆)	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ethambutol		
		<input type="checkbox"/> Isoniazid <input type="checkbox"/> Pyrazinamide <input type="checkbox"/> Pyridoxine (B ₆)	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ethambutol		
		<input type="checkbox"/> Isoniazid <input type="checkbox"/> Pyrazinamide <input type="checkbox"/> Pyridoxine (B ₆)	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ethambutol		
		<input type="checkbox"/> Isoniazid <input type="checkbox"/> Pyrazinamide <input type="checkbox"/> Pyridoxine (B ₆)	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ethambutol		
		<input type="checkbox"/> Isoniazid <input type="checkbox"/> Pyrazinamide <input type="checkbox"/> Pyridoxine (B ₆)	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ethambutol		
		<input type="checkbox"/> Isoniazid <input type="checkbox"/> Pyrazinamide <input type="checkbox"/> Pyridoxine (B ₆)	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ethambutol		
		<input type="checkbox"/> Isoniazid <input type="checkbox"/> Pyrazinamide <input type="checkbox"/> Pyridoxine (B ₆)	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ethambutol		
		<input type="checkbox"/> Isoniazid <input type="checkbox"/> Pyrazinamide <input type="checkbox"/> Pyridoxine (B ₆)	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ethambutol		
		<input type="checkbox"/> Isoniazid <input type="checkbox"/> Pyrazinamide <input type="checkbox"/> Pyridoxine (B ₆)	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ethambutol		
		<input type="checkbox"/> Isoniazid <input type="checkbox"/> Pyrazinamide <input type="checkbox"/> Pyridoxine (B ₆)	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ethambutol		
		<input type="checkbox"/> Isoniazid <input type="checkbox"/> Pyrazinamide <input type="checkbox"/> Pyridoxine (B ₆)	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ethambutol		