ICAP

TB SCREENING AND INH PREVENTIVE THERAPY (IPT) MONITORING TOOL (DRAFT)

I. TB SCREENING (To be filled for all newly enrolled HIV positive clients for Pre ART/ART)

Date : _____

Identification

Name _____ Age___ Sex___ Pre ART or Unique ART No [UAN] _____

TB Screening Checklist

	Y	N
* Cough >2 wks	___	___
* Fever>2 wks	___	___
* Night Sweats >2 wks	___	___
* Wt loss > 3 Kgs in the last 4 Wks	___	___
* History of TB contact in past 1 Year	___	___

Investigations for TB (If Positive screen)

Sputum AFB: [*If cough>2 weeks*]
Neg ___ Pos ___

Chest X-Ray [*If indicated*]
Normal___ Abnormal ___

Contraindications for IPT

	Y	N
Active TB	___	___
Abnormal CXR	___	___
Diagnosis of TB in past 3 years	___	___
Active hepatitis [Clinical or lab]	___	___
Pregnancy	___	___
Prior allergy to INH	___	___
known Alcoholic	___	___
Hx of poor Rx compliance	___	___

If patient has active TB ⇨ Refer for TB treatment Date of referral _____

IS PATIENT ELIGIBLE FOR IPT? Yes ___ No ___ If No, Reason _____

If yes, start IPT as per the guideline and use the follow-up chart below

II. INH PREVENTIVE THERAPY [IPT] FOLLOW UP CHART

Weight____ INH daily dose_____

Date IPT collected	TB Symptoms [cough, fever, night sweats, wt loss]			Hepatitis Symptoms [Abd pain, nausea vomiting, Abn LFT, Children: persistent irritability, yellowish urine and eyes]			Neurologic Symptoms [Numbness, tingling, paresthesia]			Rash			Adherence (≥ 80% doses = Good < 80% doses = bad)		
	Y	N	If Yes action taken	Y	N	If Yes action taken	Y	N	If Yes action taken	Y	N	If Yes action taken	Good	Bad	If Bad action taken

Outcome of IPT(Write Date): Completed _____ Defaulted_____ Died _____ Transferred out ____

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