

# TB CASE / LTBI TREATMENT COMPLETION FORM

NAME: \_\_\_\_\_

HCP: \_\_\_\_\_

DOB: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

DATE OF DIAGNOSIS: Y: \_\_\_\_\_ M: \_\_\_\_\_ D: \_\_\_\_\_

MEDICATIONS:  
(Dosage & Route)

1. \_\_\_\_\_ x \_\_\_\_\_ doses

2. \_\_\_\_\_ x \_\_\_\_\_ doses

\*\*Does not include  
doses given at SRH

3. \_\_\_\_\_ x \_\_\_\_\_ doses

4. \_\_\_\_\_ x \_\_\_\_\_ doses

5. \_\_\_\_\_ x \_\_\_\_\_ doses

6. \_\_\_\_\_ x \_\_\_\_\_ doses

START DATE: Y: \_\_\_\_\_ M: \_\_\_\_\_ D: \_\_\_\_\_

END DATE: Y: \_\_\_\_\_ M: \_\_\_\_\_ D: \_\_\_\_\_

LATEST SPUTUM DATE: Y: \_\_\_\_\_ M: \_\_\_\_\_ D: \_\_\_\_\_

RESULT: Smear \_\_\_\_\_ Culture: \_\_\_\_\_

LATEST CHEST X-RAY DATE: Y: \_\_\_\_\_ M: \_\_\_\_\_ D: \_\_\_\_\_

RESULT: \_\_\_\_\_

FURTHER FOLLOW-UP: No:

Yes:

Person Reporting: \_\_\_\_\_

Date: Y: \_\_\_\_\_ M: \_\_\_\_\_ D: \_\_\_\_\_

Place: \_\_\_\_\_

This completed form to be forwarded to :



Northwest  
Territories Health and Social Services

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Government of the Northwest Territories  
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