UTAH DEPARTMENT OF HEALTH DIRECTLY OBSERVED THERAPY LOG
12-Dose Isoniazid-Rifapentine Latent TB Infection Treatment

Patient Name: ______________________________ **Date of Birth:** ___________
Initial Weight: _____________**kg** **Dose: INH** ______mg **RPT**______mg

Date: Dose:	__/__ __1__	__/__ __2__	__/__ __3__	__/__ __4__	__/__ __5__	__/__ __6__	__/__ __7__	__/__ __8__	__/__ __9__	__/__ __10__	__/__ __11__	__/__ __12__
Loss of appetite	□	□	□	□	□	□	□	□	□	□	□	□
Nausea or vomiting	□	□	□	□	□	□	□	□	□	□	□	□
Yellow eyes or skin Dark urine or light color stool	□	□	□	□	□	□	□	□	□	□	□	□
Diarrhea	□	□	□	□	□	□	□	□	□	□	□	□
Rash or hives	□	□	□	□	□	□	□	□	□	□	□	□
Fever or chills	□	□	□	□	□	□	□	□	□	□	□	□
Sore muscles	□	□	□	□	□	□	□	□	□	□	□	□
Numbness or tingling	□	□	□	□	□	□	□	□	□	□	□	□
Methadone withdrawal*	□	□	□	□	□	□	□	□	□	□	□	□
Dizziness/lightheaded	□	□	□	□	□	□	□	□	□	□	□	□
Unusual bleeding/bruising	□	□	□	□	□	□	□	□	□	□	□	□
Rx stop or held	□	□	□	□	□	□	□	□	□	□	□	□
No adverse reaction	□	□	□	□	□	□	□	□	□	□	□	□
Current Weight	kg	kg	kg	kg	kg	kg	kg	kg	kg	kg	kg	kg
Blood Pressure	/	/	/	/	/	/	/	/	/	/	/	/
HCW Initials**												

* ($\geq$ 3 new symptoms for $\geq$ 7 days) nausea and vomiting, abdominal cramps, body aches, restlessness, irritability, dilated pupils, tremors, involuntary twitching, lacrimation, rhinorrhea, sneezing, yawning, excessive perspiration, goose flesh, or diarrhea

** Printed name for initials: ____ ________________________ | ____ __________________________ | ____ _______________________
Initials Printed name Initials Printed name Initials Printed name

Final Disposition: □Completed treatment □Stopped treatment □ adverse event □ lost to f/u □ moved □ other

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Final Disposition Date: ______________________

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Laboratory Log

If levels are abnormal, please describe in Comments section. Include abnormal level(s) and action taken.

	Date	Date	Date	Date	Date	Date	Date	Date
LFT	normal abnormal ________	normal abnormal ________	normal abnormal ________	normal abnormal ________	normal abnormal ________	normal abnormal ________	normal abnormal ________	normal abnormal ________
CBC	normal abnormal ________	normal abnormal ________	normal abnormal ________	normal abnormal ________	normal abnormal ________	normal abnormal ________	normal abnormal ________	normal abnormal ________

Adverse Event Episode Log

Please complete for any adverse event which causes interruption in therapy, and notify State TB Nurse Consultant (801)538-9906.

Date	Onset of symptoms	Symptom Duration	Hospitalized	# doses taken	Rechallenge	Outcome
	□ < 2 hrs □ 2-48hrs □ >48hrs	□ < 1 day ___hrs □ > 1 day ___days	□ yes □ no		□ yes □ no	□ continue Rx □ INH intolerant □RPT intolerant
	□ < 2 hrs □ 2-48hrs □ >48hrs	□ < 1 day ___hrs □ > 1 day ___days	□ yes □ no		□ yes □ no	□ continue Rx □ INH intolerant □RPT intolerant
	□ < 2 hrs □ 2-48hrs □ >48hrs	□ < 1 day ___hrs □ > 1 day ___days	□ yes □ no		□ yes □ no	□ continue Rx □ INH intolerant □RPT intolerant
	□ < 2 hrs □ 2-48hrs □ >48hrs	□ < 1 day ___hrs □ > 1 day ___days	□ yes □ no		□ yes □ no	□ continue Rx □ INH intolerant □RPT intolerant

Report event requiring hospitalization within one business day.

Comments

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