

Patient Name: \_\_\_\_\_

Health Center: \_\_\_\_\_

**STANDARD INFORMATION LOG: 12-Dose Isoniazid-Rifapentine Latent TB Infection Treatment Dose and Symptom Monitoring**

PF No: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F Ethnicity: Hispanic / Non-Hispanic Race: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs Height: \_\_\_\_\_ ft/inches

Treatment reason:  Contact  Corrections  Homeless  Refugee  Foreign-born  Convertor Dose: INH \_\_\_\_\_ mg RPT \_\_\_\_\_ mg

**\*Check  symptoms or events reported on the listed date; otherwise, leave blank.**

Date: Dose:	__/__/__ 0 Baseline	__/__/__ 1	__/__/__ 2	__/__/__ 3	__/__/__ 4	__/__/__ 5	__/__/__ 6	__/__/__ 7	__/__/__ 8	__/__/__ 9	__/__/__ 10	__/__/__ 11	__/__/__ 12
Directly Observed Therapy (DOT) received	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No adverse reaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yellow eyes or skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rash/hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever or chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore muscles or joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Other) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treatment stopped or held (complete AE report on last page)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Final Disposition:  Completed INH-RPT treatment  
 Stopped INH-RPT treatment Date \_\_/\_\_/\_\_  
 Lost to follow-up  
 Death  
 Other  
 Adverse event (fill out last page if treatment stopped for AE)  
 Pending Completion of Alternate Regimen

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**(CHECK (✓) or COMPLETE ALL SECTIONS THAT APPLY):**

**MEDICAL RISK FACTORS AND HISTORY:**

- Diabetes (type) \_\_\_\_\_
- Chronic renal disease ( on dialysis)
- Immunocompromised (diagnosis \_\_\_\_\_)
- Hepatitis ( B  C  Other \_\_\_\_\_)
- Alcoholism
- Current or past smoker (pack-years \_\_\_\_\_)
- Other \_\_\_\_\_
- None

**HIV STATUS:**

- Positive  Negative  Unknown/Not tested

**POPULATION RISK FACTORS DURING LAST 12 MONTHS:**

- Homeless or SRO/Shelter resident
- Incarcerated (prison, jail, juvenile hall)
- Long-term care facility resident
- Health care worker
- Migrant worker
- Employee - homeless shelter
- Employee - correctional facility
- Employee - other high-risk setting \_\_\_\_\_
- Other \_\_\_\_\_
- None

**HABITS:**

- Alcohol more than 2 drinks per day:
- IDU drug use: (describe) \_\_\_\_\_
- Non-IDU drug use: (describe) \_\_\_\_\_
- None

**MEDICATIONS:**

- Warfarin (blood thinner)
- Statins (cholesterol-lowering drugs)
- Methadone
- Diabetes medicines (list): \_\_\_\_\_
- Blood pressure medications (list): \_\_\_\_\_
- TNF- $\alpha$  inhibitors\* (biologic agents used for rheumatoid arthritis, psoriasis, and other auto-immune inflammatory diseases)
- Other (list): \_\_\_\_\_
- None

Liver function tests*	Result	Result	Result	Result
Date (mm/dd/yyyy)				
AST (0 – 35 U/L)				
ALT (0 – 35 U/L)				
Alk Phos (36 – 92 U/L)				
T. Bili (0.3 - 1.2 mg/dL)				
(Other) _____				

\* ertanecept, adalimumab, infliximab, golimumab, pegsunercept, certolizumab

\* If liver function tests are done, please report values.

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**FILL OUT ONLY FOR ADVERSE EVENTS:**

Symptom Related DOSE #	Rx Stopped or Held	Date Symptom Began	Symptom Onset after Dose	Symptom Duration	Hospital Admission	Medication Re-challenge	Outcome
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> < 2 hrs <input type="checkbox"/> 2 – 48hrs <input type="checkbox"/> > 48hrs <input type="checkbox"/> Unknown	<input type="checkbox"/> < 1 day _____ hrs <input type="checkbox"/> > 1 day _____ days <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> INH re-challenged <input type="checkbox"/> RIF/RPT re-challenged <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Continue INH/RPT <input type="checkbox"/> Switch to INH for 6 or 9 months <input type="checkbox"/> Switch to Rifampin for 4 months <input type="checkbox"/> Stopped any LTBI treatment <input type="checkbox"/> Unknown
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> < 2 hrs <input type="checkbox"/> 2 – 48hrs <input type="checkbox"/> > 48hrs <input type="checkbox"/> Unknown	<input type="checkbox"/> < 1 day _____ hrs <input type="checkbox"/> > 1 day _____ days <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> INH re-challenged <input type="checkbox"/> RIF/RPT re-challenged <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Continue INH/RPT <input type="checkbox"/> Switch to INH for 6 or 9 months <input type="checkbox"/> Switch to Rifampin for 4 months <input type="checkbox"/> Stopped any LTBI Treatment <input type="checkbox"/> Unknown

Comment: Please (briefly) describe the adverse event, including symptoms, time of onset in relation to last INH-RPT dose, duration and resolution and any other factors (other medical conditions, medications). Enter comments in text box below:

Laboratory Values (only if applicable)

Complete Blood Count	Value	Chemistry Panel	Value
Date (mm/dd/yyyy)		Date (mm/dd/yyyy)	
Hemoglobin (Men: 14–17 g/dL, Women: 12–16 g/dL)		Na (Sodium) (136–150 meq/L)	
Hematocrit (Men: 41%–51%, Women: 36%–47%)		K (Potassium) (3.5–5.0 meq/L)	
White Blood Cell Count (4.0–10 x 10 <sup>9</sup> /L)		BUN (urea nitrogen) (8–20 mg/dL)	
Platelets (150–350 x 10 <sup>9</sup> /L)		Cr (Creatinine) (0.7 – 1.3 mg/dL)	
(Other) _____		(Other) _____	

\*Normal ranges may vary from site to site; these values are provided here for general reference