Patient Label

Adverse Reaction Report Form: TB Medications

Complete in the event of death, hospitalization, or severe reaction causing long term disability

Sex: _____ Weight: _____ pounds Height:_____ feet/inches

All TB medications taken since TB treatment initiation

Medication	Date Started	Date Stopped	Medication	Date Started	Date Stopped
Ethambutol			Clofazimine		
Isoniazid			Cycloserine		
Pyrazinamide			Delamanid		
Rifampin			Ethionamide		
Rifapentine			Imipenem		
Rifabutin			Levofloxacin		
Amikacin			Linezolid		
Amoxicillin			Meropenem		
Bedaquiline			Moxifloxacin		
Capreomycin			Para-aminosalicylate		
Clarithromycin			Streptomycin		

Date Symptom Began	Symptom Onset after Dose	Symptom Duration	Hospital Admission	Outcome
	☐ < 2 hrs. ☐ 2-24 hrs. ☐ > 48 hrs. ☐ Unknown	☐ < 1 day ____hours ☐ > 1 day ____days ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Continued medications ☐ Changed regimen (describe in note below) ☐ Stopped treatment ☐ Unknown ☐ Death

Comment: Thoroughly describe the adverse event, including symptoms, time of onset in relation to last medication dose, duration and resolution, suspected cause of adverse event, other related factors (other medical conditions, medications), any medication changes and current patient status.

_____ _____ _____

Signature of person completing form Date Phone number

Fax completed form to TB Control at 804-416-5178