



Date form completed _____

Name _____
PHN _____

DOB _____
Phone number _____

Reason Therapy Stopped

- Completed therapy
- Uncooperative or refused
- Not TB
- Other: (specify) _____

Date Therapy Stopped ____/____/____

- Lost
- Adverse treatment event
- Died

If died, indicate cause of death (select one)

- Related to TB disease
- Unrelated to TB disease

Date of death ____/____/____

- Related to TB therapy
- Unknown

Reason therapy extended beyond 12 months (select all that apply)

- Rifampin resistant
- Non-adherence
- Clinically indicated
- Other (specify) _____
- Adverse drug reaction
- Treatment failure

Directions for completing dose count

- Include all treatment taken by DOT whether provided in VA or elsewhere
- Non-DOT doses should be rare and counted only if there are extenuating circumstances
- Facility doses should only be counted if facility documentation is provided
- Calculate each month's total weeks of treatment using the "Treatment completion calculation worksheet"
- From the worksheet, record the number of week of therapy in the line below
- Use the comment space below to detail non-DOT counted doses or undocumented facility counted doses, an explanation for changes in the planned treatment regimen, etc.

Total weeks of planned therapy _____	Total weeks of completed therapy _____
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Comments

