Virginia Department of Health
TB Case Completion /Discontinue Medicine Report
TB Control Program

Date form completed: _____

Name: _____ DOB: _____

PHN: _____ Phone #: _____

Date Therapy Stopped: _____

Reason Therapy Stopped:
__Completed therapy
__Lost
__Uncooperative or refused
__Adverse treatment event
__Not TB
__Died, indicate date and cause below*
__Other, explain_____

*If **died**, indicate **cause** of death (select one):
__Related to TB disease
__Related to TB therapy
__Unrelated to TB disease
__Unknown

Date of Death: _____

Reason therapy **extended beyond 12 months** (select **all** that apply)
__Rifampin resistant
__Adverse drug reaction
__Non-adherence
__Treatment failure
__Clinically indicated- other reasons
__Other, explain: _____

Did treatment follow one of the four **standard treatment regimens** listed on **p. 3** of the current treatment guidelines? *Include as **Yes:** changes in frequency or dosage of **first-line** drugs. **__Yes** **__No**

If **Yes**, complete the dose count section below. Be sure to include any **appropriately** documented **DOT** doses provided by a facility or outside of Virginia. Detail **non-DOT** doses in the space below. **Do not** include **non-DOT** doses in the dose count section.

If **No** for any reason such as resistance, intolerance, needed use of second-line drugs, mal-absorption, etc. fax all DOT sheets, medication lists, and any other related documentation to TB Control at **FAX# 804 371-0248.**

Provide dose counts as indicated:

DOT doses at **7** days per week = _____

DOT doses at **5** days per week = _____

DOT doses at **3** days per week = _____

DOT doses at **2** days per week = _____

Detail non-DOT doses here: