

Adverse Reaction Report Form: 12-Dose Isoniazid-Rifapentine Latent TB Infection Treatment

Fill out only for adverse events:

VISION #/Patient ID: _____ Name : _____ DOB: _____ Sex: M/F

Ethnicity: Hispanic/Non-Hispanic Race: _____ Weight: _____ lb Height: _____ ft/inches

Treatment reason: Contact Corrections Homeless Refugee Foreign-born Convertor Subs. Abuse

Date Started _____ Date Stopped _____ Dose: INH _____ mg RPT _____ mg

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"/> 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

Laboratory Values (only if applicable)

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

Liver function tests	Complete Blood Count	Chemistry Panel
Date (mm/dd/yyyy)	Date (mm/dd/yyyy)	Date (mm/dd/yyyy)
AST (0 – 35 U/L)	Hemoglobin (Male: 14 – 17 g/dL, Female: 12 - 16 g/dL)	Na (Sodium) (136 – 150 meq/L)
ALT (0 – 35 U/L)	Hematocrit (Male: 41% - 51%, Female: 36% - 47%)	K (Potassium) (3.5 - 5.0 meq/L)
Alk Phos (36 – 92 U/L)	White Blood Cell Count (4.0 – 10 x 10 ⁹ /L)	BUN (urea nitrogen) (8 – 20 mg/dL)
T. Bili (0.3 - 1.2 mg/dL)	Platelets (150 – 350 x 10 ⁹ /L)	Cr (Creatinine) (0.7 – 1.3 mg/dL)
(Other) _____	(Other) _____	(Other) _____

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 related factors (other medical conditions, medications).

Signature Person Completing Form

Date

Phone Number

FAX completed form to DDP-tb at 804-371-0248