BC Centre for Disease Control
Provincial Health Services Authority

Treatment Initiation Form

Client Name Last First	
Health Card Number or **Client ID**	**Date of Birth** YYYY/MM/DD
Address of Health Centre / Health Unit	**Fax**

Treatment Type

- ☐ TB Disease (Active)
- ☐ Non-Tuberculous Mycobacterium (NTM)

TB Preventive Treatment (TPT)

- ☐ Declined TPT
- ☐ Accepted TPT, please select the regimens the client is willing to accept:
  - ☐ Rifampin* 4 months daily (SAT)
  - ☐ Isoniazid & Rifapentine* 12 weeks (DOPT)
  - ☐ Isoniazid 9 months daily (SAT)

*There are a number of drug interactions with rifamycins. Refer to clinical drug interaction databases (e.g. Micromedex, Lexicomp).

Client Consent to Treatment Plan

- ☐ I was provided with education on the reason for treatment, the pills needed and their side effects.
- ☐ I have had an opportunity to ask questions.
- ☐ I agree to take pills as directed, and will report side effects if they occur.
- ☐ I agree to attend appointments for blood work, tests, and follow-up.
- ☐ I give BCCDC TB Services access to PharmaNet for information related to my TB treatment.

Client signature Date (YYYY/MM/DD)

Clinical Details

CXR ☐ Normal ☐ Abnormal **Date** _____ YYYY/MM/DD	**AST/ALT** _____U/L **Date** _____ YYYY/MM/DD	**Weight** _____ (kg)

Current Medications	Best possible medication history includes over-the-counter, herbal and other supplements, or non-prescribed substances for non-medical use.		
Allergies	Medication / Food / Environmental	Reaction	Severity
Co-existing Medical Conditions		**Supports or Barriers to Care** (e.g. transportation, work schedule, housing, accessibility)	

Coordinating Health Centre or Unit Responsibilities

- Dispense medications, monitor side effects, and ensure required blood work and CXR's are completed.
- For clients taking ethambutol, complete baseline and ongoing monitoring of visual acuity and red/green discrimination.
- Report any abnormal AST/ALT results to TB Services.
- Treatment Forms: TB Adherence and Medication Re-Order Form & Notification of Abnormal AST Form

Fax this form to the TB Services program serving your area. Ordering process may take 1-2 weeks.

BC Centre for Disease Control (604) 707-2690	**First Nations Health Authority** (604) 689-3302	**Island Health** (250) 519-1505