FORM 2G: Health Plan Implementation for CHRONIC COUGH MANAGEMENT

Part 1: HEALTH RISK ASSESSMENT & KEY HEALTH MESSAGES (Indicate Y, if 'yes'; N if 'no')

G1. Have you consulted a health provider regarding your cough? _____

(If No, Deliver Message for G1 before going to G2
If Yes, go to G2)

Message for G1
- Go to the health center for testing

G2. If consulted a health provider, what was the diagnosis? *(Please check)*

☐ TB
(Deliver Message for G2a the Go to Part 2)

Message for G2a (TB)
- Go to a TB-DOTS provider immediately for diagnosis & treatment
- TB can be treated. Free Anti-TB Drugs are available at the health center or any DOTS facility
- Patient needs to take anti-TB drugs for at least 6 months AND must be supervised by a treatment partner
- Improper treatment of TB may lead to more serious complications. Because TB is an infection transmitted thru air, and it may spread to other members of the family, especially children
- TB may cause death if left untreated or not properly treated
- Return to the health center/DOTS facility for your follow-up tests/check-ups

☐ Other diseases manifesting as chronic cough
(Deliver Message for G2b then Go to Part 2)

Message for G2b (Other cough-like diseases)
- Take your medicines as prescribed by your health provider
- Improper use of medicines may worsen your condition and could lead to a more serious illness
- Go back to your health provider for follow-up

For more information on Family Planning, see the Family Health Guide, A. Health Messages: Caring for Family Members with Chronic Cough, p. 19

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Part 2: GENERAL INFORMATION (to be filled out with the help of the CHT partner)

Name of Respondent (Last name, first name, mother's maiden name)	NHTS HH ID: □□□□□□□□–□□□□–□□□□□
Name of Guardian (Last name, first name, mother's maiden name)	
Name of CHT partner (Last name, first name, mother's maiden name)	Date of Visit when Health Plan was developed (mm/dd/yy):

Part 3: HEALTH PLAN (to be filled out with the help of the CHT partner)

Health Goal	Referral Provider/s (name and address) (use the list of health providers in the Family Health Guide)	Date of planned visit (mm/dd/yy)
☐ To go to the health facility for check-up, testing and treatment		
☐ To go to the health facility for scheduled follow-up		
☐ To continue treatment/ resupply of medication (**for TB patients**)		
☐ Others		

I/we understand the health risks and needs of our family and I/we have decided to develop this health plan.

_____
(Name and signature of respondent)

Part 4: ACTIONS TAKEN (to be filled out by the midwife, nurse or doctor)

Name and address of health provider:

Services provided:	Date of consultation (mm/dd/yy): Schedule of next check-up (mm/dd/yy):

Instruction of the provider: (For TB cases, please specify schedule of sputum exams, drug intake, and follow-up visits)

Part 5: Service Utilization and Monitoring Form for CHRONIC COUGH MANAGEMENT				
Date of consultation (mm/dd/yy)	Name and address of service provider	Service(s) provided	Instruction of the provider (including referral to higher level and schedule)	Schedule of next visit to provider for check up (mm/dd/yy)

Part 5: Service Utilization and Monitoring Form for CHRONIC COUGH MANAGEMENT				
Date of consultation (mm/dd/yy)	Name and address of service provider	Service(s) provided	Instruction of the provider (including referral to higher level and schedule)	Schedule of next visit to provider for check up (mm/dd/yy)