Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

DEC 0 1 2020

ADMINISTRATIVE ORDER
No. 2020 - 0057

SUBJECT: Guidelines on Mandatory Tuberculosis (TB) Notification

I. RATIONALE

TB ranked fifth among the top ten leading causes of mortality based on the 2017 Philippine Health Statistics. The 2016 National TB Prevalence Survey revealed that around one million Filipinos have TB and the burden remains unabated in the last ten years. The World Health Organization had estimated that around 599,000 new TB cases develop every year. Yet only 68% were notified to DOH, thus, around 189,000 are still "missing".For the past two decades, NTP had engaged them through the public-private mix DOTS initiative but many are still unengaged, hence, many cases remained unreported to NTP.

Section 8 of the Implementing Rules and Regulations issued by the Department of Health (DOH) on May 5, 2017 for Republic Act No. 10767 entitled Comprehensive Tuberculosis (TB) Elimination Plan Act stipulated that "all public and private health care providers shall report all detected TB cases in accordance with the guidelines issued by the National TB Control Program (NTP)". Making TB a notifiable disease recognizes that it is a major public health problem in the Philippines requiring an improved surveillance system.

In 2017, DOH had launched the 2017-2022 Philippine Strategic TB Elimination Plan: Phase 1 (PhilSTEP1) towards TB elimination that in general aims to reach, treat and protect TB patients. This was further detailed in the Updated PhilSTEP1 2020 – 2023 wherein TB cases reported through mandatory TB notification was included as a major program indicator to monitor TB elimination efforts in the country. Mandatory TB notification will bolster case finding, help ensure high quality TB management in both the public and private sectors, and assess progress towards TB disease elimination goals.

TB as an infectious disease for elimination is a notifiable disease that requires mandatory reporting. Mandatory reporting refers to the obligatory reporting of a condition to local or state authorities as required for notifiable diseases as stipulated in Republic Act 11332 or the Mandatory Reporting of Notifiable Diseases and Health Events of Public Health Concern Act".
The TB notification system being managed by NTP is the Integrated TB Information System (ITIS), an electronic case-based recording and reporting platform. However, it mostly captures TB cases seen and reported by the public health facilities including hospitals and few private health care providers.

In this context, it is imperative to clearly specify the policies and guidelines on mandatory TB notification to enable all health care providers to comply with the policy and for the program managers and partners to provide the necessary support.

II. OBJECTIVES

General Objective: To provide guidance on the standardized data collection, analysis, and response on mandatory TB notification that will help in the development of policies and plan to reach, treat and protect TB patients.

Specific Objectives:

1. Specify the policies and implementing guidelines on the different processes of TB notification.
2. Describe the health systems support to enable health care providers to comply with the Order.
3. Define the roles and responsibilities of key stakeholders.
4. Define the monitoring and evaluation mechanism for this Order.

III. SCOPE AND COVERAGE

These guidelines shall cover all health care providers and facilities, both public and private, who are providing part or all TB services such as diagnosis, treatment, and prevention, all DOH units including the Centers for Health Development (CHDs), Ministry of Health -Bangsamoro Autonomous Region in Muslim Mindanao (MOH - BARMM) subject to the applicable provisions of RA 11504 or the "Bangsamoro Organic Act", hospitals and attached agencies, other local government units, other concerned government agencies, partner organizations such as professional medical societies and all other concerned.

IV. DEFINITION OF TERMS

1. Bacteriologically confirmed TB – a TB patient from whom a biological specimen is positive of TB using any of the following TB diagnostic tests mentioned in the NTP manual of procedures: sputum smear microscopy, culture or WHO-endorsed rapid diagnostic tests such as Xpert MTB/Rif and TB LAMP.

2. Clinically diagnosed TB – a TB patient who does not fulfill the criteria for bacteriological confirmation but has been diagnosed with active TB by a physician who has decided to give the patient a full course of TB treatment. This definition includes cases diagnosed on the basis of X-ray abnormalities or suggestive histology, and extra-pulmonary cases without laboratory confirmation.

3. DOTS facility – a health care facility, whether public or private, that provides TB-DOTS services in accordance with the policies and guidelines of the NTP.

4. Health care providers and facility– any person, facility or organization, whether private or public, who are registered and/or licensed to provide health services to patients.

5. Integrated TB Information System (ITIS) – an electronic information system that will be used to collect, consolidate, and report TB data coming from all health facilities managing TB cases.

6. Mandatory TB notification – refers to the obligatory reporting of diagnosed tuberculosis cases and their TB treatment outcomes as stipulated in the RA 10767 or the TB Law and it's Implementing Rules and Regulations.

7. Notifiable disease – refers to a disease that, by legal requirements, must be reported to the public health or other authority in the pertinent jurisdiction when the diagnosis is made as required for notifiable diseases in reference to RA 11332 or the Mandatory Reporting of Notifiable Diseases and Health Events of Public Health Concern Act.

8. Presumptive TB – any person whether adult or child with signs and/or symptoms suggestive of TB whether pulmonary or extra-pulmonary, or those with chest x-ray findings suggestive of active TB.

9. Response – a set of actions undertaken by the unit that received the TB notification report who in turn will ensure that notified TB patient receives quality diagnostic and treatment services, contact investigation was done, infection prevention activities are implemented and data are used in improving the performance of theTB program.

10. TB surveillance – refers to the ongoing systematic collection, analysis, interpretation and timely dissemination of TB data for the planning, implementation and evaluation of NTP.

11. TB Notification Officer – a designated staff responsible for the collection, consolidation and analysis of TB notification reports. This person assists in the implementation of mandatory TB notification.

V. GENERAL GUIDELINES

1. TB is a notifiable disease, hence, health care providers and facilities, both public and private, shall notify the DOH about every diagnosed TB case using the format and processes that had been designed for this purpose.
2. The mandatory TB notification system shall be established, maintained and sustained within the TB surveillance system of the Disease Prevention and Control Bureau through the National TB Control Program (NTP).
3. In the development and updating of policies, guidelines and plan on mandatory TB notification, DOH shall adopt the principles of partnership and shared responsibility.
4. All Rural Health Units and Health Centers and designated TB Notification Officers at the municipality, city, provincial and regional levels in collaboration with NTP coordinators / point persons, shall be responsible for the collection, consolidation and analysis of TB notification reports and submission to the higher level.
5. System security measures in the information system (ITIS) are in place to secure patient confidentiality and ensure compliance with the Republic Act No. 10173 also known as Data Privacy Act of 2012. Reporting units follow the policies and procedures of the NTP in terms of recording and reporting as documented in NTP manual of procedures.
6. DOH and all local government health units (province, city and municipality), with the assistance of partners including professional societies, shall conduct advocacy and capability-building activities for all concerned agencies and units to enable the health care providers to comply with this Order.

7. DOH and other concerned agencies shall strengthen its systems to provide logistical support, enablers and incentives to all health care providers to promote and sustain their compliance.

8. The Philippine Health Insurance Corporation (PHIC), Government Security Insurance System (GSIS), Social Security System (SSS), and Employees' Compensation Commission (ECC) shall use compliance to TB notification as a claims processing requirement.
9. NTP shall establish and implement a monitoring and evaluation system and shall regularly update the Secretary of Health and Congress on the progress of implementation.

VI. IMPLEMENTING GUIDELINES

A. Processes for TB notification

1. Registration of a health care provider and facility

Any health care provider and facility, both public and private, who are providing part or all TB services such as diagnosis, treatment and prevention shall accomplish a TB Service Provider Information Sheet (Annex 1) and submit to KMITS through channels. Once validated, the health care providers are entered in the Integrated TB Information System (ITIS) TB Care Providers Database and health care facilities in the TB Care Facilities Database.

2. Identifying a TB case

Every case of TB, whether bacteriologically confirmed or clinically diagnosed shall be reported to DOH. These include the following cases but not limited to:

a. initiated or provided treatment
b. referred to another health provider or facility for treatment
c. refused treatment

Duplication of and repeat reports will be filtered by ITIS.

The NTP Manual of Procedures and clinical practice guidelines issued by professional societies describe the algorithm and guidelines to diagnose TB. Identified presumptive TB shall undergo diagnostic tests such as sputum smear microscopy and/or WHO endorsed rapid diagnostic test to confirm diagnosis of TB.

All health facilities providing TB diagnostic services such as but not limited to laboratory or radiological tests shall ensure that patients with diagnostic results suggestive or confirmatory of TB are referred to the requesting health care providers or facilities. Mandatory TB notification by diagnostic facilities shall be covered in second phase of implementation.

3. Notification and reporting of TB cases

The registered health care provider and/or designated facility encoder shall notify all diagnosed and/or treated TB cases by the end of each the month using a TB case notification form or through ITIS. Zero case reporting is likewise required. For provinces/cities/municipalities with a designated TB Notification Officer, the physician

shall submit the notification to the them for encoding in ITIS. TB Notification Officers will assist the encoding of TB cases in ITIS.

To notify, the physician shall;

a. Explain to the TB patient the need to notify him/her to DOH as mandated in RA 10767 with emphasis on confidentiality in accordance with RA 10173.
b. Fill-out the TB Case Notification Form (Annex 2), either manually or electronically. For DOTS Facilities, open a TB notification form or TB Treatment card (Annex 3) and encode in ITIS.Filling-out of the forms and encoding may be delegated to a trained personnel.
c. Submit the paper notification to the designated TB Notification Officer within the municipality, city or province where the health care provider or facility is located. The private providers and RHU health center staff may develop a system to facilitate submission or collection of paper-based notifications.
   Health care facilities or organizations such as hospitals or multispecialty clinics that employ many physicians shall establish a system for collection or consolidation of the TB notification forms and submission either electronically or manually.
d. Submit a zero-case report if there are no TB case within a month.
e. Report also the treatment outcome at the appropriate time (when the patient completed treatment, was lost or died).

Designated TB Notification Officer of a municipality, city, province or region shall receive the paper notification, and encode in ITIS.

4. Data analysis and interpretation

a. The designated TB Notification Officer and the designated NTP Program Coordinator shall review and analyze the ITIS-generated reports.
b. Findings shall be shared with the head of the facility and other key staff.

5. Feedback and response

The designated TB Notification Officer shall:

a. Contact the reporting person/ unit to verify the report and to inquire whether the patient had been initiated treatment or if referred to another facility, and if whether a referral feedback had been received.
b. Check ITIS whether the concerned patient had been correspondingly encoded.
c. Ensure those who are notified and not yet initiated treatment within 2 weeks are traced and motivated to report for treatment by health center staff or volunteer. Document reasons for refusal to be treated.
d. Give a feedback to health care provider who referred their TB cases to another facility.
e. Provide information to the TB program that will use the data for planning and policy development.

(The first 2 steps are for manual reporting).

B. Health system support

1. Information system

DOH – KMITS shall develop a simple web-based user registration and reporting system that will facilitate reporting of TB for private health care providers and facilities.

This shall be a sub-module of the ITIS. Facilities with their own information system that captures the required fields shall also link with ITIS.

2. **Human resources**
Units at all levels, from regional and provincial/city to municipal health offices, including hospitals shall designate a specific person/s to act as TB Notification Officer.

3. **Health care provider and facilities inventory**
Municipalities and cities through its health offices shall conduct mapping and inventory of all the health care providers and facilities seeing TB patients. The CHD shall supervise this mapping process. The providers, either individually or as a group, shall be encouraged to join the service delivery network to facilitate referral, provision of services and notification. The list shall be submitted to the higher level and consolidated in ITIS.

4. **Advocacy and capability building**
DOH in partnership with professional medical societies and other stakeholders shall develop capability-building modules and materials and train the regional, provincial and city trainers. These trainers shall convene all the health care providers and conduct orientation / training on the TB notification system. Other forms of information dissemination shall also be used.

5. **Logistics support and enablers**
DOH, through its CHDs and the Provincial / City Health Offices (P/CHOs), shall ensure the adequacy of logistics of the concerned health facilities for TB diagnosis, treatment, and prevention. Private care providers who comply with NTP protocol as described in the MOP may be provided with these logistical supports. DOH shall ensure provision of innovative incentive / enabler system to motivate compliance of health providers to TB notification.

C. Monitoring and Evaluation System

A Monitoring and Evaluation System shall be developed and implemented by NTP. Some of the key indicators are:

- Timeliness and accuracy of reporting
- Proportion of health care facilities notifying TB patients
- Proportion of identified private health care providers notifying TB patients
- Percent contribution of MN reports to total notified TB cases
- Percent increase in the TB case notification rate
- Percent of notified cases put on treatment
- Treatment outcome of notified TB cases

A joint monitoring team from the province/city and region shall regularly visit the reporting health care providers and facilities and shall analyze reports to determine accomplishment of the M&E indicators. DPCB shall prepare an annual report and submit this to the Secretary of Health and Congress through channels.

VII VI. Roles and responsibilities of stakeholders

A. DOH – Disease Prevention and Control Bureau

a. Formulate policies and guidelines on the diagnosis, treatment, and prevention of TB;

b. Develop and disseminate policies and guidelines and simple recording and reporting system for mandatory TB notification;
c. Plan and implement advocacy and communication activities on mandatory TB notification to all stakeholders;
d. Develop capability-building courses and conduct training of trainers in coordination with partners including professional societies;
e. Provide technical assistance on mandatory TB notification to CHDs, P/CHOs, and LGUs;
f. Ensure adequacy of logistics such as forms, laboratory supplies, and anti-TB drugs for the concerned participating health care providers;
g. Develop and implement mechanisms to motivate / incentivize the providers to notify all their TB patients and sustain the initiative in coordination with PHIC and partners;
h. Develop mechanisms to sustain the mandatory TB notification in coordination with development partners and other organizations; and
i. Review performance and identify challenges and corresponding solutions related to mandatory TB notification.

B. DOH – Epidemiology Bureau

a. Assist DPCB in the analysis and interpretation of data.

C. DOH – Knowledge Management and Information Technology Service

a. Develop and implement the online electronic registration, recording and reporting system of the mandatory TB notification and integrate this to ITIS and other DOH electronic reporting system;
b. Maintain the electronic recording and reporting system of the mandatory TB notification including providers and facilities databases;
c. Assess potential and recommend options for data capture or sharing opportunities for mandatory TB notification with existing private sector electronic recording and reporting system; and
d. Assist in capability-building on mandatory TB notification and use of ITIS.

D. Centers for Health Development

a. Communicate and disseminate NTP policies, guidelines, advocacy, and Information, Education and Communication (IEC) materials to all provinces and highly urbanized cities and municipalities for further distribution to all providers;
b. Designate regional TB Notification Officers who shall oversee implementation at the provincial, city, and municipal levels;
c. Develop the capability of provinces, cities, and municipalities through trainings, orientations, and reviews to implement the mandatory TB notification;
d. Provide technical assistance and support for engagement activities of provinces, cities, and municipalities;
e. Work closely with provinces, cities, and municipalities to map and annually update all engaged and unengaged providers and strengthen the TB services within each service Health Care Provider Network (HCPN);
f. Consolidate, analyze, interpret, and submit data on mandatory TB notification;
g. Support the provinces, cities, and municipalities to supply anti-TB drugs, laboratory equipment and supplies, and other TB commodities to the providers who need them for their patients; and

h. Review and monitor program performance and the challenges faced related to mandatory TB notification, initially on a quarterly basis and later on an annual basis.

E. Provincial, City and Municipal Health Offices

a. Identify and designate TB Notification Officers for the implementation of the mandatory TB notification;
b. Map and enlist all care providers annually and submit this list to the respective Center for Health Development;
c. Work closely with the respective Center for Health Development and the cities and municipalities to strengthen the TB services within each HCPN;
d. Collect monthly paper reports from the providers who are not using electronic methods for mandatory TB notification, and upload the data to the electronic database within 15 days from the end of each month;
e. Consolidate, analyze, and submit quarterly programmatic reports to the Center for Health Development, and use the reports for evidence-based local decision-making;
f. Conduct monitoring visits to health care providers and health facilities; and
g. Support the providers with anti-TB drugs, laboratory equipment and supplies, and other TB commodities, on case-need basis.

F. Designated TB Notification Officers – Region, Province, City, Municipal, and Facility Level

a. Develop a regularly updated list of private practitioners in their area;
b. Orient these providers on the mandatory TB notification guidelines – either as a group or individually;
c. Provide technical support on the reporting of cases;
d. Upload to the notification electronic system the submitted paper-based reports;
e. Validate the submitted reports;
f. Assist in issuing a certificate of case notification for claims processing; and
g. Follow-up whether TB patients had been initiated treatment.

G. Hospitals, Clinics, and Health Maintenance Organizations (HMOs)

a. Provide a regularly updated listing of affiliated (active and visiting) physicians;
b. Facilitate the orientation of staff on mandatory TB notification;
c. Establish a system to implement, sustain, and monitor the notification process as prescribed by this Order; and
d. Designate a TB Notification Officer.

H. Health Care Providers

a. Register in the TB Notification Providers' Database;
b. Notify all diagnosed and/or treated TB cases following the prescribed procedures in this Order;
c. Issue certificate of case notification for claims processing; and
d. Provide TB services following national protocol and standards of TB care.

I. Philippine Health Insurance Corporation (PHIC), Government Security Insurance System (GSIS), Social Security System (SSS), and Employees' Compensation Commission (ECC)

a. Support mandatory TB notification activities; and

b. Align their standard procedures to include mandatory TB notification as a requirement for claims processing.

J. Professional Medical Societies

a. Support mandatory TB notification activities; and
b. Support in the dissemination of NTP policies, guidelines, advocacy, and Information, Education and Communication (IEC) materials.

~~VII~~ VIII. REPEALING CLAUSE

The provisions of previous Orders and other related issuances inconsistent or contrary with the provisions of this Administrative Order are hereby revised, modified, repealed or rescinded accordingly. All other provisions of existing issuances which are not affected by this Order shall remain valid and in effect.

~~VIII~~ IX. EFFECTIVITY

This Order shall take effect fifteen (15) days after its publication in the Official Gazette or in any newspaper of general circulation.

FRANCISCO T. DUQUE III, MD, MSc
Secretary of Health

ANNEX-A

	Knowledge Management and Information Technology Service	Page No.	Page 1 of 1
		Revision No.	0
	Service Request Form	Effectivity:	May 02, 2014

Reference Code: _____

1) Date of Request (mm/dd/yyyy): ____ / ____ / _____

2) Name of Contact Person: _____
Last Name First Name Middle Name

3) Office:

4) Address:

5) Landline: | 6) Fax No. | 7) Mobile No.

8) **DESCRIPTION OF REQUEST**: (*Please clearly write down the details of the request.*)

NEW ACCOUNT

Creation of ITIS User Account/s for:
(Please check)
- ☐ **WEB**
- ☐ **DESKTOP** (for DOTS only)

Type of Facility: (Please check)
- ☐ **Office**
- ☐ **DOTS**
- ☐ **iDOTS**
- ☐ **PMDT - TC/STC**
- ☐ **Referring Hospital**
- ☐ **QA Center**
- ☐ **TB Microscopy Laboratory**
- ☐ **RTDL**
- ☐ **DST/TB Culture Laboratory**
- ☐ **Non-NTP**
- ☐ **Others** (please specify): _____

Person Requesting Account			E-mail Address	Contact No.	User Level	Facility Name & Location
First Name	Middle Initial	Last Name				
Example: Sonia	S.	Balita	sbalita@gmail.com.	0900-000-0000	DOTS Validator	Rural Health Unit, Municipality, Province

9) **APPROVED BY:** _____ _____
Name & Signature of Head of Office Date Signed

_____
Position

(For Knowledge Management and Information Technology Service only)

10) Date Received (mm/dd/yyyy): ____ / ____ / ____ 11) Time Received (hh:mm) ____ : ____ ☐AM ☐PM

12) **ACTIONS TAKEN:** (*Use separate sheet if necessary*)

DATE (a)	TIME (b)	ACTION TAKEN (c)	ACTION OFFICER (d)	SIGNATURE (e)

13. NOTED BY:	14.	15.
Name and Signature of Supervisor	Position	Date Signed

ANNEX-B

FORM 4A. TB NOTIFICATION FORM

Privacy Notice: It has been explained to me that all information collected in this form shall only be used for the purposes of clinical management, program management, and/or provision of psychosocial and financial support. If I have any query on or wish to revoke this authorization, I shall notify the facility head or contact ntp.helpdesk@doh.gov.ph or (02) 8230-9626. All information collected shall remain secured and confidential and only authorized personnel shall have access to them.

Patient's Signature over Printed Full Name

Reason of Notification: [ ] New/ Diagnosis [ ] Update/Start of Treatment *Please put an * or highlight on fields updated.* [ ] Final Outcome

Name of Facility:	**NTP Facility Code:**	**Province/ HUC:**	**Region:**

A. Patient Demographic

Patient's Full Name (SURNAME, Given Names, Name Extension, Middle Name):	**Date of Birth** (MM/DD/YYYY):	**Age:** YEARS MONTHS	**Sex** (M/F):	**Civil Status:**

Permanent Address (House No., Street, Barangay, City/ Municipality, Province, Region & Zip Code):	**Contact Number** (include area code):	**Nationality:**
	PhilHealth No.:	

B. Laboratory Tests

Name of Test:	Xpert MTB/RIF [ ] ULTRA	Smear Microscopy/TB LAMP	Chest X-ray	Tuberculin Skin Test	Other: _____
Date (MM/DD/YYYY):	Collection	Collection	Examination	Reading	
Result:					

C. Diagnosis

Diagnosis:	**Date of Diagnosis** (MM/DD/YYYY):	**Date of Notification** (MM/DD/YYYY):	**Referred To** (Name, Address, Facility Code, Province/HUC, Region):
[ ] TB Disease [ ] TB Infection	**TB/ TPT Case Number:**	**Attending Physician:**	

D. TB Disease Classification

Bacteriological Status:	**Drug Resistance Bacteriological Status:**	**Registration Group:**
[ ] Bacteriologically-confirmed TB [ ] Clinically-diagnosed TB	[ ] Drug-susceptible [ ] Bacteriologically-confirmed XDR-TB	[ ] New [ ] TAF
Anatomical Site:	[ ] Bacteriologically-confirmed RR-TB [ ] Clinically-diagnosed MDR-TB	[ ] Relapse [ ] PTOU
[ ] Pulmonary [ ] Extra-pulmonary SITE: _____	[ ] Bacteriologically-confirmed MDR-TB [ ] Other Drug-resistant TB _____	[ ] TALF [ ] Unknown History

C. Diagnosis

Regimen Type at Start of Treatment:

[ ] Regimen 1 2HRZE/4HR
[ ] Regimen 2 2HRZE/10HR
[ ] Regimen 3 SSOR 4LfxBdq(6)CfzPtoEZHdH/5LfxCfzZE
[ ] Regimen 4 SLOR FQ-S 6LfxBdqLzdCfz/12LfxLzdCfz
[ ] Regimen 5 SLOR FQ-R 6LzdBdqDlmCfzCs
[ ] Regimen 6 __ PEDIA MDR FQ-S
a LfxLzdCfzCs(Pas/Eto)
b LfxLzdCfzCs(Dlm/PAS)
c BdqLfxLzdCfz (Cs/Dlm)
[ ] Regimen 7__ PEDIA MDR FQ-R
a LzdCfzCsPAS (Eto/Dlm)
b LzdCfzCsDlm (PAS/Eto)
c BdqLzdCfzCs (Dlm/PAS)
[ ] ITR (specify) _____
[ ] BPaL
[ ] 6H
[ ] 3HP
[ ] 3HR
[ ] 4R

Treatment Start Date (MM/DD/YYYY):	**Regimen Type at End of Treatment:**

F. Treatment Outcome

Regimen Type at Start of Treatment:

Outcome: [ ] Cured [ ] Failed [ ] Died
[ ] Treatment Completed [ ] Lost to Follow-up

Date of Outcome (MM/DD/YYYY):

Reason (if Failed, LTFU, or Died):

FORM 4B. DS-TB TREATMENT CARD

ANNEX -C

Privacy Notice: It has been explained to me that all information collected in this form shall only be used for the purposes of clinical management, program management, and/or provision of psychosocial and financial support. If I have any query on or wish to revoke this authorization, I shall notify the facility head or contact ntp.helpdesk@doh.gov.ph or (02) 8230-9626. All information collected shall remain secured and confidential and only authorized personnel shall have access to them.

Patient's Signature over Printed Full Name

I. Case Finding/ Notification

Name of Diagnosing Facility:	NTP Facility Code:	Province/ HUC:	Region:

A. Patient Demographic

Patient's Full Name (SURNAME, Given Names, Name Extension, Middle Name):		Date of Birth (MM/DD/YYYY):	Age: YEARS MONTHS	Sex (M/F):	Civil Status:
Permanent Address (House No., Street, Barangay, City/ Municipality, Province, Region & Zip Code):		Current Address (House No., Street, Barangay, City/ Municipality, Province, Region & Zip Code):			
Contact Number (include area code):	Other Contact Information:	PhilHealth No.:	Nationality:		

B. Screening Information

Referred by (Name & Location): [ ] public [ ] other public [ ] private [ ] community	Mode of Screening: [ ] PCF [ ] ACF [ ] ICF [ ] ECF	Date of Screening (MM/DD/YYYY):

C. Laboratory Tests

Name of Test:	Xpert MTB/RIF [ ] ULTRA	Smear Microscopy/TB LAMP	Chest X-ray	Tuberculin Skin Test	Other: _____
Date (MM/DD/YYYY):	Collection	Collection	Examination	Reading	
Result:					

D. Diagnosis

Diagnosis:	Date of Diagnosis (MM/DD/YYYY):	Date of Notification (MM/DD/YYYY):	Referred To (Name, Address, Facility Code, Province/HUC, Region):
[x] TB Disease [ ] TB Infection	TB Case Number:	Attending Physician:	

E. TB Disease Classification

Bacteriological Status:	Drug Resistance Bacteriological Status:	Registration Group:
[ ] Bacteriologically-confirmed TB [ ] Clinically-diagnosed TB	[ ] Drug-susceptible [ ] Bacteriologically-confirmed RR-TB [ ] Bacteriologically-confirmed MDR-TB [ ] Bacteriologically-confirmed XDR-TB [ ] Clinically-diagnosed MDR-TB [ ] Other Drug-resistant TB _____	[ ] New [ ] TAF [ ] Relapse [ ] PTOU [ ] TALF [ ] Unknown History
Anatomical Site: [ ] Pulmonary [ ] Extra-pulmonary SITE: _____		

II. Treatment

Name of Treatment Facility:	NTP Facility Code:	Province/ HUC:	Region:

A. Baseline Information

History of TB Treatment (most recent on top): [ ] None

Date Tx Started	Name of Treatment Unit	Treatment Regimen (Drugs & Duration)	Outcome

HIV Information:
[ ] Known PLHIV Prior to Start of Tx [ ] Not Eligible for Testing

HIV Test Date (MM/DD/YYYY):

Confirmatory Test Date (MM/DD/YYYY):

Result: [ ] P [ ] N [ ] undetermined
Started on ART? [ ] Yes [ ] No
Started on CPT? [ ] Yes [ ] No

Height: CM **Weight:** KG

Other Vital Signs or Treatment Considerations:

Person to Notify in case of Emergency:

Relationship:

Contact Information:

Diabetes Screening:
[ ] Known Diabetic [ ] Not Eligible

FBS Screening: mg/dl **Date Tested:**

4Ps Beneficiary?
[ ] Yes [ ] No

Co-morbidities: [ ] No Known

Date Diagnosed	Type	Treatment
	[ ] Diabetes Mellitus	
	[ ] Mental Illness	
	[ ] Substance Abuse	
	[ ] Liver Disease	
	[ ] Renal Disease	
	[ ] Other: _____	
	[ ] Other: _____	

Occupation:
[ ] HCW

B. Treatment Regimen

Regimen Type at Start of Treatment:
[ ] Regimen 1
2HRZE/4HR
[ ] Regimen 2
2HRZE/10HR

Treatment Start Date (MM/DD/YYYY):

Regimen Type at End of Treatment:

C. Treatment Outcome

Outcome:
[ ] Cured [ ] Failed [ ] Died
[ ] Treatment Completed [ ] Lost to Follow-up

Date of Outcome (MM/DD/YYYY):

Reason (if Failed, LTFU, or Died):

National TB Control Program

TB Case No. _____

Date Start (MM/DD/YYYY):	**Drug:**	4FDC	2FDC	H	R	Z	E	
	Strength:	150/ 75/ 400/ 275 mg	150/75 mg	mg	mg	mg	mg	
	Unit:	tablet	tablet					

E. Serious Adverse Events and AEs of Special Interest

Date of AE (MM/DD/YYYY)	**Specific AE**	**Date Reported to FDA** (MM/DD/YYYY)

D. Administration of Drugs

Location of Treatment:	**Name, Designation, and Type of Tx Supporter:**	**Tx Supporter Contact Information:**	[ ] DAT-supported
[ ] Facility-based [ ] Community-based [ ] Home-based	[ ] Facility HCW [ ] Community HCW [ ] Family [ ] Lay Volunteer [ ] Others	**Schedule of Treatment:**	**Name of DAT/s Used:**

Intensive Phase Start Date (MM/DD/YYYY):	**IP End Date** (MM/DD/YYYY):	**Continuation Phase Start Date** (MM/DD/YYYY):	**CP End Date** (MM/DD/YYYY):

#	**Month** (MMM-YY)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Monthly Doses Taken	Cum. Doses Taken	Monthly Missed Doses	% Adher.	Weight (kg)	Height (cm) for Children
0																																						
1																																						
2																																						
3																																						
4																																						
5																																						
6																																						
7																																						
8																																						
9																																						
10																																						
11																																						
12																																						

Legend:

Tx Supporter 3-letter initials: Supervised
I: Incomplete Regimen
HOLD: On hold

STC/ TS/ CB/ HB: Satellite Treatment Center/ Treatment Site/ Community-Based/ Home-based DOT
X: Drugs not taken/ Absent
Re-challenge: Drug re-challenge

Encircle date of regimen change
Double slash on shift to CP
[brackets] - drugs dispensed to patient or treatment supporter

TB Case No. _____

F. Patient Progress Report Form

Month	Date	Problem (Adverse Event, Reason of Absence)	Action Taken	Plan	Health Staff Signature

G. Close Contacts

Name	Age	Sex (M/F)	Relationship	Initial Screening (MM/DD/YYYY)	F!-up (MM/DD/YYYY)	Remarks (TB/ TPT Case Number)

H. Sputum Monitoring

	Date Collected (MM/DD/YYYY)	Smear Microscopy/ TB LAMP	Xpert MTB/RIF
S1			
S2			
B		/	
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

I. Chest X-ray

Month	Date Examined (MM/DD/YYYY)	Impression/ Comparative Reading	Descriptive Comments
B		[ ] Normal [ ] Abnormal suggestive of TB [ ] Abnormal not suggestive of TB	
		[ ] Improved [ ] Stable/Unchanged [ ] Worsened	
		[ ] Improved [ ] Stable/Unchanged [ ] Worsened	

J. Post Treatment Follow-up

Mo. After Tx	Date (MM/DD/YYYY)	CXR Findings	Smear/ Xpert	TBC & DST
PT				
PT				
PT				

ANNEX - D

FORM 4C. DR-TB TREATMENT CARD

Privacy Notice: It has been explained to me that all information collected in this form shall only be used for the purposes of clinical management, program management, and/or provision of psychosocial and financial support. If I have any query on or wish to revoke this authorization, I shall notify the facility head or contact ntp.helpdesk@doh.gov.ph or (02) 8230-9626. All information collected shall remain secured and confidential and only authorized personnel shall have access to them.

Patient's Signature over Printed Full Name

I. Case Finding/ Notification

Name of Diagnosing Facility:	NTP Facility Code:	Province/ HUC:	Region:

A. Patient Demographic

Patient's Full Name (SURNAME, Given Names, Name Extension, Middle Name):		Date of Birth (MM/DD/YYYY):	Age: YEARS MONTHS	Sex (M/F):	Civil Status:
Permanent Address (House No., Street, Barangay, City/ Municipality, Province, Region & Zip Code):		**Current Address** (House No., Street, Barangay, City/ Municipality, Province, Region & Zip Code):			
Contact Number (include area code):	**Other Contact Information:**	**PhilHealth No.:**	**Nationality:**		

B. Screening Information

Referred by (Name & Location): [ ] public [ ] other public [ ] private [ ] community	Mode of Screening: [ ] PCF [ ] ACF [ ] ICF [ ] ECF	Date of Screening (MM/DD/YYYY):

C. Laboratory Tests

Name of Test:	Xpert MTB/RIF [ ] ULTRA	Smear Microscopy/TB LAMP	Chest X-ray	Tuberculin Skin Test	Other: _____
Date (MM/DD/YYYY):	Collection	Collection	Examination	Reading	
Result:					

D. Diagnosis

Diagnosis:	Date of Diagnosis (MM/DD/YYYY):	Date of Notification (MM/DD/YYYY):	Referred To (Name, Address, Facility Code, Province/HUC, Region):
[x] TB Disease [ ] TB Infection	TB Case Number:	Attending Physician:	

E. TB Disease Classification

Bacteriological Status:	Drug Resistance Bacteriological Status:	Registration Group:
[ ] Bacteriologically-confirmed TB [ ] Clinically-diagnosed TB	[ ] Drug-susceptible [ ] Bacteriologically-confirmed XDR-TB [ ] Bacteriologically-confirmed RR-TB [ ] Clinically-diagnosed MDR-TB [ ] Bacteriologically-confirmed MDR-TB [ ] Other Drug-resistant TB _____	[ ] New [ ] TAF [ ] Relapse [ ] PTOU [ ] TALF [ ] Unknown History
Anatomical Site:		
[ ] Pulmonary [ ] Extra-pulmonary SITE: _____		

II. Treatment

Name of Treatment Facility:	NTP Facility Code:	Province/ HUC:	Region:

A. Baseline Information

History of TB Treatment (most recent on top): [ ] None

Date Tx Started	Name of Treatment Unit	Treatment Regimen (Drugs & Duration)	Outcome

HIV Information:
[ ] Known PLHIV Prior to Start of Tx [ ] Not Eligible for Testing

HIV Test Date (MM/DD/YYYY):

Confirmatory Test Date (MM/DD/YYYY):

Result: [ ] P [ ] N [ ] undetermined
Started on ART? [ ] Yes [ ] No
Started on CPT? [ ] Yes [ ] No

Height: CM **Weight:** KG

Other Vital Signs or Treatment Considerations:

Person to Notify in case of Emergency:

Relationship:

Contact Information:

Diabetes Screening:
[ ] Known Diabetic [ ] Not Eligible

FBS Screening: mg/dl **Date Tested:**

4Ps Beneficiary?
[ ] Yes [ ] No

Co-morbidities: [ ] No Known

Date Diagnosed	Type	Treatment
	[ ] Diabetes Mellitus	
	[ ] Mental Illness	
	[ ] Substance Abuse	
	[ ] Liver Disease	
	[ ] Renal Disease	
	[ ] Other: _____	
	[ ] Other: _____	

Risk Factor/s for DR-TB:
[ ] Retreatment
[ ] Close Contact of a Confirmed DR-TB
[ ] Non-converter of a DS-TB Regimen

Occupation:
[ ] HCW

C. Diagnosis

Regimen Type at Start of Treatment:

[ ] Regimen 3 SSOR
4LfxBdq(6)CfzPtoEZHdH/5LfxCfzZE

[ ] Regimen 4 SLOR FQ-S
6LfxBdqLzdCfz/12LfxLzdCfz

[ ] Regimen 5 SLOR FQ-R
6LzdBdqDlmCfzCs

[ ] Regimen 6 __ PEDIA MDR FQ-S
a LfxLzdCfzCs(Pas/Eto)
b LfxLzdCfzCs(Dlm/PAS)
c BdqLfxLzdCfz (Cs/Dlm)

[ ] Regimen 7__ PEDIA MDR FQ-R
a LzdCfzCsPAS (Eto/Dlm)
b LzdCfzCsDlm (PAS/Eto)
c BdqLzdCfzCs (Dlm/PAS)

[ ] ITR (SPECIFY) _____

[ ] BPaL

Treatment Start Date (MM/DD/YYYY):	Regimen Type at 6th Mo. of Treatment:	Regimen Type at End of Treatment:

D. Treatment Outcome

Outcome
[ ] Cured
[ ] Treatment Completed
[ ] Failed
[ ] Died
[ ] Lost to Follow-up

Date of Outcome (MM/DD/YYYY):

Reason (if Failed, LTFU, or Died):

D. Laboratory and Diagnostic Tests

	B	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Scheduled Tests																									
Alanine (ALT)/ SGPT	/																								
Aspartate Transaminase (AST)/ SGOT	/																								
Albumin																									
Creatinine	/																								
Blood Urea Nitrogen	/																								
Uric Acid																									
Potassium	/																								
Calcium																									
Magnesium																									
Glucose (Fasting Blood Sugar)	/																								
Hbg / Hct	/																								
WB Count	/																								
Platelet Count	/																								
Thyroid Stimulating Hormone	/																								
Lipase/ Amylase																									
Visual Acuity: Snellen Chart	/																								
Visual Acuity: Ishihara	/																								
Pregnancy Test	/																								
Electrocardiogram	/																								
Mental Health Screening	/																								
Brief Peripheral Neuropathy Screen	/																								
Audiometry																									
Other																									
Unscheduled Tests																									

National TB Control Program

TB Case No. _____

Date Start (MM/DD/YYYY):	Drug:	H	R	Z	E	Lfx	Lfx	Mfx	Bdq	Lzd	Cfz	Cfz	Cs	Dlm	Imp	Mpm	Am	S	Pto	PAS	Amx-Clv			B6
	Strength:	300 mg	300 mg	500 mg	400 mg	250 mg	500 mg	400 mg	100 mg	600 mg	50 mg	100 mg	250 mg	50 mg	500 mg	1g	500 mg	1 g	250 mg	4g	875/125 mg			50 mg
	Unit:	tab	cap	tab	tab	tab	tab	tab	tab	tab	tab	tab	cap	tab	vial	vial	vial	vial	tab	sachet	tab			tab

E. Administration of Drugs

Location of Treatment:	Name, Designation, and Type of Tx Supporter:	Tx Supporter Contact Information:	[ ] DAT-supported
[ ] Facility-based [ ] Community-based [ ] Home-based	[ ] Facility HCW [ ] Community HCW [ ] Family [ ] Lay Volunteer [ ] Others	Schedule of Treatment:	Name of DAT/s Used:

Intensive Phase Start Date (MM/DD/YYYY):	IP End Date (MM/DD/YYYY):	Continuation Phase Start Date (MM/DD/YYYY):	CP End Date (MM/DD/YYYY):

#	Month (MMM-YY)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Monthly Doses Taken	Cum. Doses Taken	Monthly Missed Doses	% Adher.	Weight (kg)	Height (cm) for Children
0																																						
1																																						
2																																						
3																																						
4																																						
5																																						
6																																						
7																																						
8																																						
9																																						
10																																						
11																																						
12																																						

Legend:

Tx Supporter 3-letter initials: Supervised
I: Incomplete Regimen
HOLD: On hold

STC/ TS/ CB/ HB: Satellite Treatment Center/ Treatment Site/ Community-Based/ Home-based DOT
X: Drugs not taken/ Absent
Re-challenge: Drug re-challenge

Encircle date of regimen change
Double slash on shift to CP
[brackets] - drugs dispensed to patient or treatment supporter

TB Case No. _____

#	Month (MMM-YY)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Monthly Doses Taken	Cum. Doses Taken	Monthly Missed Doses	% Adher.	Weight (kg)	Height (cm) for Children
13																																						
14																																						
15																																						
16																																						
17																																						
18																																						
19																																						
20																																						
21																																						
22																																						
23																																						
24																																						

F. TB Medical Advisory Committee Meetings and Decisions

Date (MM/DD/YYYY)	Reason for Presentation	Details	Decision
	Start of Treatment		
	End of Treatment		

G. Serious Adverse Events and AEs of Special Interest

Date of AE (MM/DD/YYYY)	Specific AE	Date Reported to FDA (MM/DD/YYYY)

H. Patient Progress Report Form

Month	Date	Problem (Adverse Event, Reason of Absence)	Action Taken	Plan	Health Staff Signature

TB Case No. _____

Month	Date	Problem (Adverse Event, Reason of Absence)	Action Taken	Plan	Health Staff Signatue

TB Case No. _____

I. Sputum Monitoring

	Date Collected (MM/DD/YYYY)	Smear Microscopy/ TB LAMP	TBC
S1			GX:
S2			GX:
B		/	/
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			

J. Drug-Susceptibility Testing

Date Collected (MM/DD/YYYY)	Date Released (MM/DD/YYYY)	Method	H	R	E	Z	Lfx	Mfx	Pto/ Eto	Am	S		

K. Chest X-ray

Mo.	Date Examined (MM/DD/YYYY)	CXR Findings	Remarks
B		[ ] Normal [ ] Abnormal suggestive of TB [ ] Abnormal not suggestive of TB	
		[ ] Improved [ ] Stable/Unchanged [ ] Worsened	
		[ ] Improved [ ] Stable/Unchanged [ ] Worsened	
		[ ] Improved [ ] Stable/Unchanged [ ] Worsened	
		[ ] Improved [ ] Stable/Unchanged [ ] Worsened	

L. Close Contacts

Name	Age	Sex (M/F)	Relationship	Initial Screening (MM/DD/YYYY)	Ff-up (MM/DD/YYYY)	Remarks (TB/ TPT Case Number)

M. Post Treatment Follow-up

Mo. After Tx	Date (MM/DD/YYYY)	CXR Findings	DSSM	LPA	TBC & DST	Remarks
PT 6						
PT 12						
PT						
PT						

Post-Treatment Outcome:
[ ] Non-relapsing Cure [ ] Lost to Follow-up
[ ] Relapse [ ] Died

Date of Post-Tx Outcome (MM/DD/YYYY):

Reason (IF LTFU, OR DIED):