

MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE

PATIENT CONTRACT FOR ISONIAZID THERAPY FOR TUBERCULOSIS INFECTION

OTSG APPROVED (Date)

1. I understand that (my) (my child's) tuberculosis (TB) skin test is positive and this means that sometime in the recent or distant past (I have) (my child has) been infected by the TB germ. I understand that (I have) (my child has) not developed active TB and that the medication (INH) can help to prevent active TB.

2. I agree to (take my) (give my child) INH as prescribed every day for ____ months. If (I have) (my child has) any of the following symptoms: loss of appetite, nausea, weakness, unexplained fatigue, weight loss, dark urine (tea or coffee color), light stools, tingling of the hands or feet, yellow color of skin or eyes, rash or any other unexplained illness, I will contact (my) (my child's) doctor or the Community Health Nurse and tell him/her.

3. If (I am) (my child is) seen in another clinic or at a hospital, I will inform the doctor or nurse that (I am) (my child is) taking INH. I will also report all other medications that have been prescribed for (me) (my child).

4. I understand that (I) (my child) will routinely be given an INH prescription for 30 days at a time. (I) (My child) will see the doctor or Community Health Nurse every month, as recommended, for (my) (my child's) INH refill.

5. I realize that I am responsible for (taking my) (giving my child) INH daily as prescribed and will contact (my) (my child's) doctor or the Community Health Nurse immediately if (I) (my family) will PCS, be on leave for an extended period of time, or if I lose the medication.

6. If I am assigned to another installation while (I am) (my child is) taking INH, I will contact a doctor or the Community Health Nurse at the next military medical treatment facility to obtain an appointment.

PATIENT/GUARDIAN SIGNATURE: _____

DATE: _____

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)

- HISTORY/PHYSICAL
- OTHER EXAMINATION OR EVALUATION
- DIAGNOSTIC STUDIES
- TREATMENT
- FLOW CHART
- OTHER (Specify)