

**UTAH DEPARTMENT OF HEALTH DIRECTLY OBSERVED THERAPY LOG
12-Dose Isoniazid-Rifapentine Latent TB Infection Treatment**

Patient Name: _____

Laboratory Log

If levels are abnormal, please describe in Comments section. Include abnormal level(s) and action taken.

| | Date |
|-----|--------------------|--------------------|--------------------|--------------------|--------------------|--------------------|--------------------|--------------------|
| LFT | normal
abnormal |
| CBC | normal
abnormal |

Adverse Event Episode Log

Please complete for any adverse event which causes interruption in therapy, and notify State TB Nurse Consultant (801)538-9906.

Date	Onset of symptoms	Symptom Duration	Hospitalized	# doses taken	Rechallenge	Outcome
	<input type="checkbox"/> < 2 hrs <input type="checkbox"/> 2-48hrs <input type="checkbox"/> >48hrs	<input type="checkbox"/> < 1 day ___ hrs <input type="checkbox"/> > 1 day ___ days	<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> continue Rx <input type="checkbox"/> INH intolerant <input type="checkbox"/> RPT intolerant
	<input type="checkbox"/> < 2 hrs <input type="checkbox"/> 2-48hrs <input type="checkbox"/> >48hrs	<input type="checkbox"/> < 1 day ___ hrs <input type="checkbox"/> > 1 day ___ days	<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> continue Rx <input type="checkbox"/> INH intolerant <input type="checkbox"/> RPT intolerant
	<input type="checkbox"/> < 2 hrs <input type="checkbox"/> 2-48hrs <input type="checkbox"/> >48hrs	<input type="checkbox"/> < 1 day ___ hrs <input type="checkbox"/> > 1 day ___ days	<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> continue Rx <input type="checkbox"/> INH intolerant <input type="checkbox"/> RPT intolerant
	<input type="checkbox"/> < 2 hrs <input type="checkbox"/> 2-48hrs <input type="checkbox"/> >48hrs	<input type="checkbox"/> < 1 day ___ hrs <input type="checkbox"/> > 1 day ___ days	<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> continue Rx <input type="checkbox"/> INH intolerant <input type="checkbox"/> RPT intolerant

Report event requiring hospitalization within one business day.

Comments
