RÉGIE RÉGIONALE DE LA SANTÉ ET DES SERVICES SOCIAUX DU NUNAVIK
NUNAVIK REGIONAL BOARD OF HEALTH AND SOCIAL SERVICES

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UNGAVA TULATTAVIK HEALTH CENTER
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EMBOSSER ICI LA CARTE DU CSI OU CSTU, SI NON DISPONIBLE, INSCRIRE LES NOM, PRÉNOM, DATE DE NAISSANCE ET NUMÉRO DE DOSSIER

EMBOSS THE CARD OF THE IHC OR UTHC HERE, IF NOT AVAILABLE, WRITE THE NAME, SURNAME, DATE OF BIRTH AND FILE NUMBER

REGISTRATION OF THE MEDICATION – Latent TB infection (LTBI)

3HP DOT (Directly Observed Therapy) (Rifapentine and Isoniazid) – Adult AND child (2 to 65 years)

Treatment start date[1]: ____/_____/____   Treatment end date[2]:____/_____/____

Duration of the treatment and number of doses to give: 12 doses over 12 weeks, maximum of 16 weeks

Enter the dosage prescribed by the physician:	⏩ Notify the treating physician and Public Health team if:	⏩ Discontinue treatment on medical order if :
Rifapentine (RPT) _____ mg po DOT 1 X week Isoniazid (INH) ______ mg po DOT 1 X week Vitamin B6 ________ mg po DOT 1 X week } = 1 dose	a) 2 consecutive doses are missed over a period of 2 weeks b) 3 doses are missed over a period of 6 weeks c) Only 6 doses have been taken at week 11	Less than 6 doses taken at week 12

IMPORTANT: A missed dose can be administered on the next acceptable day during the same week, AS LONG AS THE MINIMUM TIMEFRAME OF 72 HOURS BETWEEN THE DOSES IS COMPLIED WITH AND THAT NO MORE THAN 5 DOSES ARE ADMINISTERED OVER A PERIOD OF 28 DAYS.

Week	Monday[3,4]	Tuesday[3,4]	Wednesday[3,4]	Thursday[3,4]	Friday[3,4]	Saturday[3,4]	Sunday[3,4]	Total[5]
Week 1	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	
Week 2	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	
Week 3	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	
Week 4	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	
Week 5	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	
Week 6	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	
Week 7	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	
Week 8	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	
Week 9	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	
Week 10	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	
Week 11	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	
Week 12	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	
Fill in the lines below if the treatment extends beyond 12 weeks.								
Week 13	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	
Week 14	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	
Week 15	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	
Week 16	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	YY/MM/DD ____	

Degree of compliance at the end of the treatment[6]: □ **Inadequate (< 11 doses over 16 weeks)** □ **Acceptable (≥ 11 doses over the max. of 16 weeks)** □ **Optimal (12 doses/12 weeks)**

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[1]Enter the date on which the first dose was taken.
[2]Enter the date on which the last dose was taken.
[3]Enter the date and the nurse's initials once the dose has been administered; enter X if the patient did not show up for his dose.
[4]Before each dose is administered, fill in the tool *Weekly clinical evaluation* for the 3HP and advise the physician of the presence of any symptoms.
[5] Calculate the cumulative (total) number of doses given.
[6] Once the treatment has ended, check the total number of doses taken, determine the degree of compliance and based on the latter, prepare a follow-up plan as indicated in the *Clinical and radiological follow-up guide*.

Signature and permit no.	Initials	Signature and permit no.	Initials	Signature and permit no.	Initials