MDR/RR-TB treatment card

Patient's name and surname:..... : ..... Registration N°: .....

Sex: ☐ M ☐ F Date of birth: ...../...../..... Weight (kg): .....

Address[a]/phone number: .....

Name/phone number of a person to contact if necessary: .....

Facility: ..... Date of treatment start: ...../...../.....

Name of prescriber: ..... Name of treatment supporter: .....

Treatment regimen: .....

Month: Drugs and doses	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	
																																Nb of prescribed days:
																																Nb of days missed or incomplete:
																																Adherence %:

[a] If homeless, indicate usual locations.