**สรุปแบบติดตามการรักษา**

**ชื่อ - สกุล …………………………..…………................................. TB No. ……………….............……………HN……..……....………**

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| **เดือนที่** | | **ว/ด/ป ส่งตรวจ**  **Smear วันที่รับผล** | **ผล ds** | **ว/ด/ป ส่งตรวจ**  **Culture วันที่รับผล** | **ผล Culture** | **ว/ด/ป ส่ง CXR** |
| **0** | |  |  |  |  |  |
| **สิ้นเดือนที่** | **1** |  |  |  |  |  |
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| **20** |  |  |  |  |  |

**ผลการเพาะเชื้อและทดสอบความไวของยา**

**หมายเหตุ :** \*1.Xpert 2.LPA 3.PCR 4.Conventional Solid 5. Conventional Liquid

S = Susceptible R = Resistant

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| **ว/ด/ป.**  **ที่ส่งตรวจ** | **ว/ด/ป.**  **รับผล** | **\*วิธีการตรวจ** | **ผล DST** | | | | | | | | | | | | |
| **INH** | **RMP** | **EMB** | **PZA** | **Bdq** | **Lzd** | **FQs** | **Cs** | **Cfz** | **Dlm** | **Am/ CAP** | **Eto /Pto** | **PAS** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**Treatment card สำหรับ MDR / XDR TB**

**เดือนที่ 1 (ว/ด/ป......./........../........)**

ชื่อ ............................................................................นามสกุล .............................................................................

อายุ......................................ปี เลขที่บัตรประชาชน

ที่อยู่ ......................................................................................................................................................................

โทรศัพท์ที่ติดต่อได้ ...............................................................................................................................................

ประวัติการเจ็บป่วย...............................................................................................................................................

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**การขึ้นทะเบียนรักษา**

วินิจฉัย และเริ่มการรักษาที่สถานพยาบาลนี้ เมื่อ ....................................................................................

รักษาจากโรงพยาบาลอื่นๆ (ระบุ) ............................................. เป็นเวลา................................................

ตั้งแต่................................................ ถึง ................................................ แล้วส่งต่อมาที่สถานพยาบาลนี้

**โรคที่เป็นร่วม(ระบุ)**.................................................................................................................................................

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**การตรวจภาพรังสีทรวงอก**

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| --- | --- |
| (............................ /............................ /............................) | (............................ /............................ /............................) |

**น้ำหนัก .......................................... กิโลกรัม**

**สูตรยา**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **ยา** | **ขนาดยาต่อวัน** | **การบริหารยา** |  | **การตรวจทางห้องปฏิบัติการ** | |
|  |  |  |  | **HIV** |  |
|  |  |  |  | **FBS** |  |
|  |  |  |  | **BUN / Cr** |  |
|  |  |  |  | **LFT** |  |
|  |  |  |  | **อื่นๆ** |  |
|  |  |  |  |  |  |

**DOT**

**เจ้าหน้าที่สาธารณสุข อาสาสมัคร ญาติ ระบุชื่อ..............................................**

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| เดือน............................ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | |  |
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| เดือน................................ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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**การตรวจพื้นฐานอื่น ๆ**

1. การได้ยิน................................................................................................................................................

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2. การมองเห็น............................................................................................................................................

................................................................................................................................................................... **การประเมินอื่นๆ** ปัญหาเศรษฐกิจ /ปัญหาครอบครัว /ปัญหาสุขภาพจิต

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**เดือนที่** ................................ **(ให้ใช้แบบฟอร์มนี้ตั้งแต่ เดือนที่ 2 เป็นต้นไป)**

**น้ำหนัก** ...........................**....กิโลกรัม**

**ผลตรวจเสมหะ**

**สเมียร์** (ว/ด/ป ที่ส่งตรวจ)...............................................ผล.......................................................................

**การเพาะเชื้อ** (ว/ด/ป ที่ส่งตรวจ).....................................ผล........................................................................

**อาการ / อาการแสดง**..................................................................................................................................

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| เดือน............................ . | | | | | | | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
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| 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |  |
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| เดือน............................... | | | | | | | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
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| 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |  |
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**บันทึกเพิ่มเติม (**โดยเฉพาะอาการที่ไม่พึงประสงค์จากยา**)**

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