

MDR TB SUPPLEMENTAL SURVEILLANCE FORM

To be completed for all cases treated as MDR TB, regardless of DST results

DOH 343-233 November 2022

History of treatment before current episode with second-line TB drugs for the treatment of TB disease (not LTBI):

 Yes No Unknown

TREATMENT COURSE

Date MDR TB therapy started for current episode:

Month / Day / Year:

 / /

Drugs ever used for MDR TB Treatment, from MDR start date: (Select one option for each drug)

Drug	Length of time administered		
Isoniazid	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Rifampin	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Pyrazinamide	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Ethambutol	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Streptomycin*	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Rifabutin*	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Rifapentine*	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Ethionamide*	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Amikacin*	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Kanamycin*	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Capreomycin*	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Ciprofloxacin*	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Levofloxacin*	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Ofloxacin*	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Moxifloxacin*	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Other Fluoroquinolones	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Cycloserine*	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Para-Amino Salicylic Acid*	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Linezolid*	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Bedaquiline*	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Delamanid*	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Clofazimine*	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Pretomanid*	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month
Other (Specify: _____)	<input type="checkbox"/> Not Used	<input type="checkbox"/> < 1 month	<input type="checkbox"/> ≥ 1 month

*Indicates second- or third-line medication for purpose of US surveillance

Date injectable medication was stopped:

Month

Day

Year

 Not Applicable

Was surgery performed to treat MDR TB?

 Yes

 No

If YES, Date:

Month

Day

Year

Side effects

Side effect	Experienced?			When?		
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> During Treatment	<input type="checkbox"/> At end of treatment	<input type="checkbox"/> Both
Suicide attempt or ideation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> During Treatment	<input type="checkbox"/> At end of treatment	<input type="checkbox"/> Both
Cardiac abnormalities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> During Treatment	<input type="checkbox"/> At end of treatment	<input type="checkbox"/> Both
Hearing loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> During Treatment	<input type="checkbox"/> At end of treatment	<input type="checkbox"/> Both
Tinnitus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> During Treatment	<input type="checkbox"/> At end of treatment	<input type="checkbox"/> Both
Vestibular dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> During Treatment	<input type="checkbox"/> At end of treatment	<input type="checkbox"/> Both
Peripheral neuropathy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> During Treatment	<input type="checkbox"/> At end of treatment	<input type="checkbox"/> Both
Renal dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> During Treatment	<input type="checkbox"/> At end of treatment	<input type="checkbox"/> Both
Vision change/loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> During Treatment	<input type="checkbox"/> At end of treatment	<input type="checkbox"/> Both
Liver toxicity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> During Treatment	<input type="checkbox"/> At end of treatment	<input type="checkbox"/> Both
Myalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> During Treatment	<input type="checkbox"/> At end of treatment	<input type="checkbox"/> Both
Arthralgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> During Treatment	<input type="checkbox"/> At end of treatment	<input type="checkbox"/> Both
Other (Specify: _____)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> During Treatment	<input type="checkbox"/> At end of treatment	<input type="checkbox"/> Both