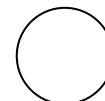


MEMO

From

Ref. in

Tel. No.

Fax. No.

Date

To Consultant Chest Physician i/c

(Attn.: Statistics Unit, Wanchai Chest Clinic)

Your Ref. in

dated Fax. No. 25728921

Total Pages

Notification of case to RR/MDR-TB Registry at Wanchai Chest Clinic

I would like to notify a case of rifampicin-resistant TB (RR-TB), with/ without* bacillary resistance to isoniazid, as follows:

Name:					
Sex *:	M ⁰ / F ¹	DOB (dd/mm/yyyy):	/	/	
HKID / Passport / Travel document number *:					
Ethnicity *: Chinese / Asians (pl specify: _____) / Others: _____					
Residence *: Permanent / New immigrant (in HK < 7 yrs) / Imported worker/ Tourist (2-way permit /other*) / Illegal immigrant / Unknown					
Chest clinic /Hospital admission /HA clinic number *:					
Site of RR/MDR-TB *: Pulmonary ¹ / Extrapulmonary (EP) ² / Both ³ (Specify EP site: _____)					
Pretreatment phenotypic drug susceptibility testing results:		(S) ⁰	(R) ¹	(S) ⁰	(R) ¹
	H (Isoniazid)	<input type="checkbox"/>	<input type="checkbox"/>	E (Ethambutol)	<input type="checkbox"/>
	R (Rifampicin)	<input type="checkbox"/>	<input type="checkbox"/>	S (Streptomycin)	<input type="checkbox"/>
Baseline results of molecular tests for resistance-associated mutations:					
Isoniazid	<i>inhA</i> : no data <input type="checkbox"/>	present <input type="checkbox"/>	absent <input type="checkbox"/>	<i>katG</i> : no data <input type="checkbox"/>	present <input type="checkbox"/>
Rifampicin	<i>rpoB</i> : no data <input type="checkbox"/>	present <input type="checkbox"/>	absent <input type="checkbox"/>		
HIV status *: -ve ⁰ / +ve ¹ / not checked ⁹ / status cannot be disclosed					
Past TB Rx >=1 month prior to development of RR/MDR-TB *: N ⁰ / Y ¹ / unknown ⁹					
Date of start of second line treatment (dd/mm/yyyy): / /					

Use of drugs (Circle one or more as appropriate)

- | | | |
|----------------|-------------------------------------|--------------------|
| a. Linezolid | f. Fluoroquinolones | (Drug name: _____) |
| b. Delamanid | g. Injectables | (Drug name: _____) |
| c. Bedaquiline | h. Pretomanid | |
| d. Clofazimine | i. Other 2 nd line drugs | (_____) |
| e. Cycloserine | j. Not applicable | |

Case referred to Chest Clinic (name):

(if applicable): Chest Hospital/ others (name):

Remarks:

Signature:

Name of doctor:

*Circle as appropriate

Notes:

1. Please enclose a copy of the laboratory drug susceptibility report and/or molecular ST report(s).
2. A copy of this form should preferably be filed in the patient's medical record for future reference.