Tuberculosis Medication Side Effect Check List – To be reviewed with each dose

It is the responsibility of the Public Health Nurse to ensure that this form is utilized, and if problems are identified, to take steps to ensure patient safety through consultation with Communicable Disease/Immunization Coordinator and/or Home Care Case Coordinator/Resource Coordinator as appropriate.

Client name:_____D.O.B.:_____

Date ➔										
Nausea										
Vomiting										
Jaundice										
Abdominal Pain										
Tingling hands or feet										
Eye problems										
Joint pain										
Skin-rash										
Loss of appetite										
Diarrhea										
Rash										
Bruising/ bleeding										
*Flu like symptoms										
Initials ➔										

*Flu-like symptoms (fever, chills, dizziness, pain in limbs shortness of breath)

Mark – *No* - if no symptom noted by HCW or client
Mark – *Yes* –if symptoms are noted, and progress note required
Note: If side effects are present please notify your supervisor for next steps.

Observer Signature **Initials**

_____ _____

_____ _____

_____ _____