Recording & Reporting

Maintenance of accurate records and registers of patients and programme activities; and reporting data to the state/central unit, is essential for proper monitoring and management of Revised National Tuberculosis Control Programme (RNTCP). RNTCP records and reports are standardized and provide the required information for managing the programme effectively
The following standardized records are used in the RNTCP

Forms	Registers
Referral Slip	Tuberculosis Laboratory Register
Laboratory request Form for Specimen Examination	Culture and DST Laboratory Register
Tuberculosis Treatment Card	Tuberculosis Notification Register
DR-TB Treatment Card	Second line TB treatment register
Patient's TB Identity Card	Stock Register
DR-TB patient identity card	Reconstitution Register
Referral form for treatment	
Referral form for treatment of DR-TB	
Transfer Form	

RNTCP request form for examination of biological specimen for TB (Annexure 15A)

The request form is kept at all the PHIs. It is filled generally by the MO of the referring health facility. This form is used for microscopy or CBNAAT or culture DST or Chest X-Ray or TST. Only one form is filled for each patient. Patient will report to the diagnostic health facility along with the request form. In case PHI is a sputum collection centre, sputum samples are sent to the diagnostic facility along with the request form. It is essential to record patient details, reason for testing and type of test requested. The same form is sent back to the treating unit with the results. When this format is used for C&DST, a copy of this form will be sent electronically to lab and DTC. In turn, the laboratory will send the result in electronic copy back to district with copy to DR-TB centre.

RNTCP referral slip (Annexure 15B)

The referral slips are used by peripheral health workers like ASHA, AWW, Link Workers etc. to refer patients to health facilities where specimen is collected either for examination or for transportation. This referral slip has contact details and symptoms of patient. At these health facilities, RNTCP request form for examination of biological specimen for TB is filled up by Medical Officer. (While printing Referral Slips, printing of Serial Number may be considered)

Tuberculosis Treatment Card (Annexure 15C)

Treatment card is filled at the PHI when patient is initiated on treatment. This card contains important information about a patient, such as: Name, age, sex and address of the patient; Type of disease; history of anti-TBtreatment; Regimen prescribed; Duration of treatment; Amount of drugs to be given; Results of investigation before and during treatment; Drugs administered during the intensive and continuation phases of treatment; Treatment outcome of the patient; Retrieval actions for missing doses; Adverse event, Preventive treatment for children; details of X-ray or other tests for diagnosis of EP TB; information on TB comorbidity and Remarks. It also has information on the treatment supporter, person conducting the initial home visit and the signature of the MO. An additional treatment card should be kept, if treatment supporter is not at health facility. In such cases, treatment supporter should be trained on recording treatment card.

Patient's TB Identity Card (Annexure 15D)

Identity card is completed for each patient who has a Tuberculosis Treatment Card. It is kept with the patient. Information from the Tuberculosis Treatment Card is used to complete the identity card. The front part of the ID card has patient information, name and address of the TU/ district and treatment details of patient including disease classification, type of patient, weight bands, smear results, category and information on the date of starting treatment. The back portion of the ID card has the results of follow-up smear examination, appointment dates for visits for drug administration and treatment outcome. This information will help to continue treatment in case the patient is transferred, or admitted to any other health facility anytime during the treatment period.

RNTCP PMDT Treatment Card (Annexure 15E)

This card is a key instrument for the treatment supporter administrating drugs daily to the patient. The card will be initiated at the DR-TB Centre when the patient is admitted for staring treatment. However for those patients who are not willing for admission the card will be initiated by the DTO. The card should be updated daily, ticking off the administration of drugs by the treatment supporter. The card is the source to complete and periodically update the PMDT register. The original treatment card will be maintained at the DR-TB Centre and a copy will be kept at treatment supporter. Accountable systems have to be developed locally for updating cards at all levels. When or if the patient moves from the DR-TB Centre to his/her district of residence a copy of the card, must follow the patient. A copy of this card may be used as a notification form and to inform about final outcome of treatment.

RNTCP PMDT Patient Identity Card (Annexure 15F)

When a patient is diagnosed as having DR-TB and is placed on a Regimen for DR TB, RNTCP PMDT patient identity card should be filled out by the health care provider at the same time that the treatment card is filled out. The card should be kept by the patient. The card, which is wallet-sized, contains the name, age, sex, PMDT TB number, essential information about the treatment (start date, regimen, and severe adverse reactions to drugs), and the details of the health centre and treatment supporter where the patient will receive treatment. Mention date of missed doses and date and result of all follow up cultures in the space under Intensive and Continuation Phase. It also has a place to write the date of the next appointment for follow up at DTC and the DR-TB Centre.

Referral/Transfer form for treatment (Annexure 15G)

Referral / Transfer form for treatment is kept at all health facilities. Medical officer of the diagnostic health facility which refers patients for treatment to other peripheral health facilities needs to fills in the top half of the form which includes the patient characteristics. Once the patient arrives, the receiving unit fills in the bottom half of the form, and sends it back to the referring unit. Information regarding referral of patient should also be noted in the TB notification register.

Referral / Transfer form is to be used when transferring registered patients on treatment from one reporting unit to another. If a patient is being 'Transferred Out', a Referral / Transfer Form and a copy of the Tuberculosis Treatment Card will be sent from the “transferring unit”, i.e.,referring health facility / TU to the “receiving unit”, i.e., health facility/ TU where the patient will receive further treatment. The first part of the form contains information about the patient, her/hisdisease, treatment details and address of the transferring unit. This information should be used to complete a new Tuberculosis Treatment Card for the patient, who would be re-registered as a “transfer in” case in the receiving unit. When the patient has reported to the receiving unit, the bottom part of the form is completed by the receiving unit and returned to the transferring unit. It is to communicate patients' follow up examination results at the end of intensive phase and treatment outcome to the transferring unit.

RNTCP PMDT Referral for Treatment Form(Annexure 15H)

This form has to be filled for all confirmed MDR or XDR TB cases that are referred from one centre to another centre. The form has to be filled by the doctor of the referring centre in duplicate and one copy sent along with the copy of the current treatment card to the referred centre. This form can be used for referring the patient at various points in time during the management of the patient between the PHI, DTC and DR-TB Centre for reasons like initiation of treatment, adverse drug reaction, transfer out, ambulatory treatment or any other reason. Incases that are transferred out, a copy of the updated PMDT treatment card must also be sent along with the referral for treatment form.

TB Notification register(Annexure 15I)

A TB notification register is maintained at each peripheral health facility. This register contains records of all patients diagnosed with TB and eligible for TB treatment, regardless of initiation of treatment. It will also incorporate those cases initiated on first line treatment and offered drug susceptibility testing and results are awaited. The registration data is based on the date on which a TB patient is diagnosed.

If patient is put on treatment in area of facility where s/he is diagnosed then information on treatment and follow up is recorded in the same TB notification register. If patient is treated in area other than where h/she is diagnosed then information on treatment and follow up is recorded in TB notification register of health facility where patients is residing.

In each health facility, TB notification register is maintained by its staff. STS of the respective TB units will support updation and coordination for completing the information.

For every patient, status of treatment should be recorded. The status of treatment for any patient would one of the following:

1. Initiated on First line treatment in the same Health Facility
2. Initiated on second line treatment in the same Health Facility
3. Initiated on treatment outside Health Facility
4. Treatment initiated outside RNTCP
5. Incomplete/ incorrect address
6. Died
7. Migrated & untraceable
8. Repeat diagnosis
9. Patient already on treatment/ Follow up patient
10. Wrong diagnosis
11. Referred for treatment with pending feedback
12. Other

RNTCP PMDT Treatment Register(Annexure 15J)

This register is maintained at DR-TB centre and at the district TB centre. In contrast to the TB notification register, it is restricted to patients who have actually started on a second-line TB treatment regimen. Date of registration will be date on which a patient is initiated on second-line treatment. The patients should be entered consecutively by their date of registration.

At DR-TB Centre, Medical Officer DR-TB centre will be responsible for maintaining the register. Statistical assistant will assist in updating it in consultation with districts and CDST laboratory. For patients who are unwilling for admission at the DR-TB Centre and are initiated on treatment at the DTC, the DTO will send the requisite information to the DR-TB Centre along with a copyof the treatment card. The DR-TB Centre will register the patient and communicate the PMDTTB number to the DTO electronically.

At district level, DR-TB supervisor will be responsible for maintaining and updating the register. In district level DR-TB register, every patient residing from the respective district and registered on treatment at DR-TB Centre will be registered using the PMDT TB number given from the concerned DR-TB Centre.

Tuberculosis Laboratory Register(Annexure 15K)

It is kept at all designated microscopy centres. The Tuberculosis Laboratory Register is used to record the results of smear examinations. The LT assigns a Laboratory Serial Number for each patient who has been referred to the Laboratory for microscopy. The TB laboratory register is used to record date of specimen collection, patient information including contact details, Name of the health facility that requested the examination (e.g. primary health centre, medical college, private practitioner, NGO, etc.); Reason for examination (diagnosis and follow-up); Results of smear examinations; information on testing for comorbidity and drug sensitivity and treatment initiation status and notification number. The last two columns of the register are for the LTs signature and any remarks the LT or supervisor wishes to make. The remarks column can mention in brief the action taken for patients belonging to other TU/districts, e.g., “Referred for treatment to…” The laboratory technician should summarize the information on sputum smear examinations done during that month. This information should be summarized in the format at the end of each month, printed in the Laboratory Register itself. Patients from the following month should be started from the next new page.

Culture and DST Register (Annexure 15L)

The RNTCP laboratory register for Culture and DST is used to record CBNAAT, LPA and culture and DST examination results. This register should be compared regularly with the RNTCP PMDT register to ensure that all DR-TB cases to be started on RNTCP Regimen for DR TB are entered in the PMDT register to ensure each case diagnosed is accounted for monitoring indicators and report generation. The lab NIKSHAY ID number is a unique number, given to a patient first time his/her specimen comes the lab. On all subsequent specimen sent to the lab, the same NIKSHAY ID number is retained for the patient, but the new specimen is provided with a new lab number. This gives an opportunity to easily extract the test results of all the specimen provided by the patient and there by track his/her response to the treatment.

Stock Register

This register is maintained at state/ district/ TU drug store. It is used for recording information on stock of drugs and consumables received and issued by the health unit. The register also mentions the batch numbers and date of expiry ofdrugs and consumables. The reconstituted PWBs should be recorded in the DTC stock register as receipts. The format of the register can be referred to in the Standard Operating Procedures Manual for State Drug Stores'.

Reconstitution Register

It is maintained at all the DTCs for recording the receipt of drugs of patients who have defaulted, died, failed treatment or transferred out. Such drug boxes are reconstituted and the details thereof are also recorded in the register. The format of the register can be referred to in the 'Standard Operating Procedures Manual for State Drug Stores