



नेपाल सरकार

स्वास्थ्य व्यवस्थापन सूचना प्रणाली

सम्भावित क्षयरोग दर्ता रजिष्टर

PRESUMPTIVE TUBERCULOSIS REGISTER

स्वास्थ्य संस्थाको नाम:

जिल्ला:

नगरपालिका/गाउँ पालिका:

वडा नं.:

प्रयोग मिति:

परिमार्जित: आ.ब. २०७८/७९

आर्थिक वर्ष:

देखि

सम्म

छपाई: आ.ब. २०७८/७९

Presumptive TB Register

SN	RN	Screened Date	Name of Patient		Age		Address		Screened By		Requested/ Referred for Diagnosis					Lab result					TB Diagnosis					Treatment Status					Remarks	
		DD/YY	Name	Ethnic Code	Female	Male	District	M/RM	X-ray	Symptom	Tests type										Name of HF / Hospital	PBC	PCD	EP	Hr TB	RR/DR TB	Enrolled	Died	LFU	Referred		Referred HF Name
		YYYY	Surname				Ward No	Contact no													Address	S	X	C	L	O	Contact no.					
		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
	RN	DD /MM	Name	Ethnic Code			District	M/RM	1	2	S	X	C	L	O	Name of HF / Hospital	Result	Result	Result	Result	Result	1	2	3	4	5	1	2	3	4	Referred HF Name	
		YYYY	Surname				Ward No	Contact no			Date	Date	Date	Date	Date	Address	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	
	RN	DD /MM	Name	Ethnic Code			District	M/RM	1	2	S	X	C	L	O	Name of HF / Hospital	Result	Result	Result	Result	Result	1	2	3	4	5	1	2	3	4	Referred HF Name	
		YYYY	Surname				Ward No	Contact no			Date	Date	Date	Date	Date	Address	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	
	RN	DD /MM	Name	Ethnic Code			District	M/RM	1	2	S	X	C	L	O	Name of HF / Hospital	Result	Result	Result	Result	Result	1	2	3	4	5	1	2	3	4	Referred HF Name	
		YYYY	Surname				Ward No	Contact no			Date	Date	Date	Date	Date	Address	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	
	RN	DD /MM	Name	Ethnic Code			District	M/RM	1	2	S	X	C	L	O	Name of HF / Hospital	Result	Result	Result	Result	Result	1	2	3	4	5	1	2	3	4	Referred HF Name	
		YYYY	Surname				Ward No	Contact no			Date	Date	Date	Date	Date	Address	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	
	RN	DD /MM	Name	Ethnic Code			District	M/RM	1	2	S	X	C	L	O	Name of HF / Hospital	Result	Result	Result	Result	Result	1	2	3	4	5	1	2	3	4	Referred HF Name	
		YYYY	Surname				Ward No	Contact no			Date	Date	Date	Date	Date	Address	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	
	RN	DD /MM	Name	Ethnic Code			District	M/RM	1	2	S	X	C	L	O	Name of HF / Hospital	Result	Result	Result	Result	Result	1	2	3	4	5	1	2	3	4	Referred HF Name	
		YYYY	Surname				Ward No	Contact no			Date	Date	Date	Date	Date	Address	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	
	RN	DD /MM	Name	Ethnic Code			District	M/RM	1	2	S	X	C	L	O	Name of HF / Hospital	Result	Result	Result	Result	Result	1	2	3	4	5	1	2	3	4	Referred HF Name	
		YYYY	Surname				Ward No	Contact no			Date	Date	Date	Date	Date	Address	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	
	RN	DD /MM	Name	Ethnic Code			District	M/RM	1	2	S	X	C	L	O	Name of HF / Hospital	Result	Result	Result	Result	Result	1	2	3	4	5	1	2	3	4	Referred HF Name	
		YYYY	Surname				Ward No	Contact no			Date	Date	Date	Date	Date	Address	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	
	RN	DD /MM	Name	Ethnic Code			District	M/RM	1	2	S	X	C	L	O	Name of HF / Hospital	Result	Result	Result	Result	Result	1	2	3	4	5	1	2	3	4	Referred HF Name	
		YYYY	Surname				Ward No	Contact no			Date	Date	Date	Date	Date	Address	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	