Name: _____

**FORM 9. IPT REGISTER**

Month/Year: _____ Name of Facility: _____

| Date Consulted/ Evaluated (1) | IPT No. (2) | Name (3) | Age (4) | Sex (5) | Address (6) | Exposure/ Infection (E/I) (7) | Date IPT Started (8) | OUTCOME (9) | | | | | REMARKS (10) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Completed | Died | Failed | Lost to follow-up | Not Evaluated | |
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