TUBERCULOSIS DRUG RECORD/DIRECTLY OBSERVED THERAPY (DOT)

NAME: _____ BIRTHDATE: _____

ADDRESS: _____ PHONE: (H) _____ (W) _____

DATE:		DRUG:		BY:		DATE DC'D:	
DATE:		DRUG:		BY:		DATE DC'D:	
DATE:		DRUG:		BY:		DATE DC'D:	
DATE:		DRUG:		BY:		DATE DC'D:	
DATE:		DRUG:		BY:		DATE DC'D:	
DATE:		DRUG:		BY:		DATE DC'D:	
DATE:		DRUG:		BY:		DATE DC'D:	

DATE: _____ MED/DOSAGE VERIFIED BY: _____

DATE	ISONIAZID	RIFAMPIN	ISONARIF	PYRAZINAMIDE	ETHAMBUTOL	PYRIDOXINE	NEXT DOSE	SIGNATURE	COMMENTS

TB-DOT/

Date Reviewed/Case Manager

/

Washington State Department of Health

343-NonDOH March 2011

For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).