Directly Observed Therapy - DOT
Treatment Record for Active TB Disease

Patient Name: ____
Public Health Nurse: ______________________________________
Agency: ____
Physician: ________________________________ ________________
Pharmacy: ____
Prescription: ______________________________ ______________
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Date	Place of Visit	Prescribed Medications Oral meds/Dosage					*Adverse Reactions	Client Incentives & Enablers	PHN Signature
		INH	RIF	PZA	EMB				

*** Adverse reactions = record on Monthly Assessment Form & consult with MD ASAP**