Directly Observed Therapy - DOT
Treatment Record for Active TB Disease

Patient Name: ____
Public Health Nurse: ____
Agency: ____
Physician: ____
Pharmacy: ____
Prescription: ____
____

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**