



Missouri Department of Health and Senior Services
Tuberculosis Medication Directly Observed Therapy (DOT)

Name	Month / Year _____ / _____	Allergies																													
INH = Isoniazid RIF = Rifampin PZA = Pyrazinamide EMB = Ethambutol B-6 = Pyridoxine RPT = Rifapentine Admin Codes: D = DOT S = Self Administered F = Failed Dose (In Red) H = Held Dose DC = Discontinued SU = Set up X = Special Circumstance (If given by DOT the health care worker and patient should initial the form each day medication is given/ingested) (Notify State TB Control Program)																															
Date	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Administration Code																															
<u>Medication: (Include Dose & Frequency)</u>																															
INH																															
RIF																															
PZA																															
EMB																															
INH/RPT ***																															
B6																															
OTHER																															
Observer Initials																															
Patient Initials																															
Observer Signature	Received Training on DOT <input type="checkbox"/> Yes <input type="checkbox"/> No										LPHA Instructor Name (for DOT)																				
Patient Signature																															
Completed doses taken this month	_____ daily _____ weekly _____ 2x/wk _____ 3x/wk										Completed doses taken to date _____ daily _____ weekly _____ 2x/wk _____ 3x/wk																				

*****Required – DOT Sheet must be sent to State TB Control Program Weekly**