Texas Department of State Health Services

Tuberculosis Directly Observed Therapy Log

Name:	**DOB:**	**Sex:**
Address:	**Telephone:**	
Status: ☐ **Window Prophylaxis** ☐ **Class II** ☐ **Class III** ☐ **Class V**	**DOT Ordered By:**	**DOT Initiated: / /**

Date Ordered:	Medication/Dosage (Amount Given/Frequency)/Manufacturer/Lot Number/Expiration Date:	Date Discontinued:

Toxicity Screen: + = Yes - = No (To be completed for each client DOT encounter before patient takes medication)

MONTH/YEAR:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
**Abdominal pain/heartburn																
**Bruises, red/purple spots on skin																
**Change in heart rate																
**Convulsions																
**Dark urine (coffee-colored)																
**Dizzy, lightheaded																
**Fever or chills >3 days																
Flu-like symptoms																
Headaches																
**Jaundice (yellow skin/eyes)																
Joint pain/swelling (PZA)																
**Light colored stools, diarrhea																
**Loss of appetite																
**Malaise/fatigue																
**Nausea/vomiting																
**Numbness/tingling																
Photosensitivity (sunburn, rash, blister)																
**Skin rashes/itching																
**Sores on lips or inside mouth																
**Tendon pain, redness, swelling (FQN)																
**Unusual bleeding (nose, gums, stool, urine, etc./easy bruising) (RIF, RPT)																
**Visual problems (EMB, RBT, LZD)																
Weakness, tiredness																
Provider Initials																
Interpreter Initials																

**** = Do not give DOT Dose. Contact Nurse/Physician for further instructions.**

Date	DOT Adm	Self Adm	Dose Missed	DOT Provider's Initials	Client's Initials	Comments/Notes
/01/						
/02/						
/03						
/04/						
/05/						
/06/						
/07/						
/08/						
/09/						
/10/						
/11/						
/12/						
/13/						
/14/						
/15/						
/16/						

Continue on reverse

Toxicity Screen: + = Yes - = No (To be completed for each client DOT encounter before patient takes medication)

MONTH/YEAR:	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
**Abdominal pain, heartburn															
**Bruises, red/purple spots on skin															
**Change in heart rate															
**Convulsions															
**Dark urine (coffee-colored)															
**Dizzy, lightheaded															
**Fever or chills >3days duration															
Flu-like symptoms															
Headaches															
**Jaundice (yellow skin/eyes)															
Joint pain/swelling (PZA)															
**Light colored stools, diarrhea															
**Loss of appetite															
**Malaise/fatigue															
**Nausea/vomiting															
**Numbness/tingling															
Photosensitivity (sunburn, rash, blister)															
**Skin rashes/itching															
**Sores on lips or inside mouth															
**Tendon pain, redness, swelling (FQN)															
**Unusual bleeding (nose, gums, stool, urine, etc./easy bruising) (RIF, RPT)															
**Visual problems (EMB, RBT, LZD)															
Weakness, tiredness															
Provider Initials															
Interpreter Initials															

**** = Do not give DOT Dose. Contact Nurse/Physician for further instructions.**

Date	DOT Adm	Self Adm	Dose Missed	DOT Provider's Initials	Client's Initials	Comments/Notes
/17/						
/18/						
/19/						
/20/						
/21/						
/22/						
/23/						
/24/						
/25/						
/26/						
/27/						
/28/						
/29/						
/30/						
/31/						

DOT SUMMARY:

# Targeted DOT Doses	# DOT Doses Given	% DOT Doses Given	# Self-Administered Doses	# Missed Doses

Compliant: ☐ Yes ☐ No Quarantine Advised: ☐ Yes ☐ No Date of Control Order: Date of Court Action:

CLIENT/DOT PROVIDER AGREEMENT:

We agree to meet at _____ (Location) on (check all days that apply)

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

at _____ (Time) AM / PM for DOT medication, unless alternate arrangements are made in advance by either party.

Change in Location:_____ Day(s):_____ Time:____

Client's Signature:_____ Client's Initials:_____

DOT Provider's Signature:_____ DOT Provider's Initials:_____

DOT Provider's Signature:_____ DOT Provider's Initials:_____