VIRGINIA DEPARTMENT OF HEALTH DIVISION OF TB CONTROL DIRECTLY OBSERVED THERAPY (DOT) LOG

DOT Month:	**DOT Year:**	**DOT Case Manager:**	**Case Mgr Phone**:

Patient Name:	Med/Strength	Dosage	# Tablets	Freq/Route	Start date:	Stop date:
Patient Address:						
Patient Phone: (H) (W) (Cell)						
Patient's DOB: **Patient's Sex:** *M* *F*						
DOT Start Date: **DOT Discontinuation Date:**						

Date:	**Printed Name:**	**Signature:**	**Initials:**

DOT Site: ☐ Home ☐ Work ☐ Clinic ☐ Other_____

Mask Needed? ☐ Yes ☐ No

Day of Month	Dose #	Initials of Person Observing or Giving Medication (If Self-Administered, Check the "Self" Box and Note the Reason in the "Comment" Column)	Time When Meds. Observed	**Side Effects: If present, check and write progress note. If absent, check in the "None" column.**														
				None	Nausea/Vomiting	Abdominal Pain	Headache	Loss of Appetite	Jaundice/ Yellow Color	Numbness/ Tingling	Rash	Fatigue	Joint Pain	Visual Change	Hearing Change	Other	Case Manager Or Clinician Notified of Adverse Reaction?	Comments
1		☐ Self															☐Yes ☐No	
2		☐ Self															☐Yes ☐No	
3		☐ Self															☐Yes ☐No	
4		☐ Self															☐Yes ☐No	
5		☐ Self															☐Yes ☐No	
6		☐ Self															☐Yes ☐No	
7		☐ Self															☐Yes ☐No	
8		☐ Self															☐Yes ☐No	
9		☐ Self															☐Yes ☐No	
10		☐ Self															☐Yes ☐No	
11		☐ Self															☐Yes ☐No	
12		☐ Self															☐Yes ☐No	
13		☐ Self															☐Yes ☐No	
14		☐ Self															☐Yes ☐No	
15		☐ Self															☐Yes ☐No	
16		☐ Self															☐Yes ☐No	
17		☐ Self															☐Yes ☐No	
18		☐ Self															☐Yes ☐No	
19		☐ Self															☐Yes ☐No	
20		☐ Self															☐Yes ☐No	
21		☐ Self															☐Yes ☐No	
22		☐ Self															☐Yes ☐No	
23		☐ Self															☐Yes ☐No	
24		☐ Self															☐Yes ☐No	
25		☐ Self															☐Yes ☐No	
26		☐ Self															☐Yes ☐No	
27		☐ Self															☐Yes ☐No	
28		☐ Self															☐Yes ☐No	
29		☐ Self															☐Yes ☐No	
30		☐ Self															☐Yes ☐No	
31		☐ Self															☐Yes ☐No	