CONFIDENTIAL

Active TB Disease Medication Administration Tracking Sheet

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MINNESOTA MDH DEPARTMENT OF HEALTH

Name: _____ DOB: ____/___/____ Clinician's Name: _____

Address: _____ Clinician's Phone No.: _____

City: _____ Phone No.: _____ Parent/Guardian Name: _____

Allergies: _____ MONTH: _____ Year: _____

Administered by whom																															
Start/Stop Dates	Medication	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

INH: Isoniazid RIF: Rifampin PZA: Pyrazinamide EMB: Ethambutol B6: Pyridoxine

KEY
D=DOT done V=Video DOT done
S=Self Administered
SU=Setup
F=Failed Dose (in RED)
H=Held Dose
X=Special Circumstances
(F,H,X document on back page)

Completed doses taken this month:
___ daily
___2x/wk____3x/wk
Completed doses taken to date:
___ daily
___2x/wk____3x/wk

CURRENT MEDICATION ORDERS:

_____
_____
_____
_____
_____
_____
_____

Initials	Signature

COMMENTS ON BACK

Date	Comments