Royal College of Nursing

DOT/VOT (Form: 4)

Form 4: DOT/VOT (complete this form for every person commencing DOT TB treatment for active/ latent disease) clinic:

	Hospital no:	Case manager:	Consultant:	Assessment Date : / /
Last name:	Other names:		DOB: / /	LTBR / ETS no:
Treatment key: **given/ DNA/ self ad.**	DOT treatment start: / /	Estimated date change to dual therapy: / /	Estimated treatment completion date: / /	

TB Medication: (dosage)	**Rifater** Dose: Frequency:	**Rifinah** Dose: Frequency:	**Rifampicin** Dose: Frequency:	**Isoniazid** Dose: Frequency:	**Pyrazinamide** Dose: Frequency:	**Ethambutol** Dose: Frequency:	**Pyridoxine** Dose: Frequency:	**Other**	**Dosage date: / /** **Signature/ designation:**	
Month:									**HCW Sig.**	**Patient Sig.**
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Form 4: Continuation Sheet (notes relevant to TB treatment) Name Hospital no.

Date/time:	Notes:	Signature:

Month _____ Year_____
Doses observed: _____
Doses self administered _____
Doses missed: _____
Observed doses taken (%) _____

Action: _____
_____
_____
_____
_____

Date: ____/____/_____ Signature: _____ Name: _____ Designation: _____

Source:
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