



**TB MEDICATIONS DIRECTLY OBSERVED THERAPY RECORD**

Month/Year: \_\_\_\_\_ Health Unit: \_\_\_\_\_

Name on BC Services Card <small>LAST, FIRST</small>					DELIVERY METHOD CODES						
Client ID/PHN					H - Home visit		S - Street visit		T - clinic or facility visit		
Date of Birth <small>YYYY/MM/DD</small>		Gender/Pronouns			C - Carries		X - Missed dose				
<b>Isoniazid tablets 300 mg</b> Dosage _____ mg each time, PO Frequency _____	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		
<b>Pyridoxine (Vitamin B6) tablets 25 mg</b> Dosage _____ mg each time, PO Frequency _____	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		
<b>Rifampin capsules 300 mg</b> Dosage _____ mg each time, PO Frequency _____	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		
<b>Pyrazinamide tablets 500 mg</b> Dosage _____ mg each time, PO Frequency _____	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		
<b>Ethambutol tablets 400 mg</b> Dosage _____ mg each time, PO Frequency _____	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		
<b>Health Care Provider</b>					<b>Signature</b>						
<b>Print Name/Designation</b>					<b>Date</b> <small>YYYY/MM/DD</small>						



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Date of Birth <small>YYYY/MM/DD</small>		Gender/Pronouns			C - Carries		X - Missed dose				
Drug _____ Dosage _____ mg each time, PO Frequency _____	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		
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Health Care Provider					Signature						
Print Name/Designation					Date <small>YYYY/MM/DD</small>						