TUBERCULOSIS DOT CHECKLIST AND RECORD

TB File: _____ Primary DOT Worker: _____

Master File: _____ Supervising Nurse: _____

Client Name: _____ Phone #: _____
Surname First Middle

Gender ❑ M ❑ F Band:

D.O.B. ___ ___ ___ ___ /___ ___ /___ ___ PHN: -
yyyy mm dd

TB Medication Prescription: Date: _____

Enablers/Incentives:

Date:												
Side Effects Checklist Y = Yes N = No												
Hives * (urticaria)												
Wheezing * (bronchospasm / SOB)												
Lip Swelling * (angioedema)												
Fever / chills * (documented)												
Skin Rash *												
Watery Eyes * (conjuncitivitis)												
Yellowing of Eyes or Skin *												
Body Aches (unusual/new)												
Very Tired / Weak												
Nausea / Vomiting												
Loss of appetite												
Pain in stomach												
Dizzy / Unsteady												
Bruising or Unusual Bleeding												
Joint Pain / Swelling												
Tingling of Hands or Feet (INH)												
Trouble Seeing (EMB only)												
Other (list)												
Notes												
Nurse Notified												
Directly Observed Therapy												
Observed client swallow pills												
Time												
DOTW Initials												
Nurse Review (weekly, initials)												

*** if YES to ANY of these, HOLD DOSE & immediately advise CHN to investigate & CALL TB Services, who will advise how to proceed.**

Follow Up Tests / Reminders

Chest X-ray	Due: _____	Req. Given ❑	Completed ❑	Due: _____	Req. Given ❑	Completed ❑
Sputum (AFB)	Due: _____	Req. Given ❑	Completed ❑	Due: _____	Req. Given ❑	Completed ❑
Blood Work	Due: _____	Req. Given ❑	Completed ❑	Due: _____	Req. Given ❑	Completed ❑
Weight	Weight: _____ Date: _____			Weight: _____ Date: _____		

Initials _____	Signature _____	Designation _____
Initials _____	Signature _____	Designation _____
Initials _____	Signature _____	Designation _____
Initials _____	Signature _____	Designation _____

Directly Observed Therapy (DOT) Client Checklist and Record

Purpose To provide a record for each DOT medication dose and associated observations of side effects and symptoms.

Primary DOTW	Name of direct observed therapy worker assigned to client
Supervising Nurse	Name of nurse assigned to train, supervise and assist DOTW and is in charge of management of the client on DOT.
TBS File No.	TB control file number for this client.
Master File	The client's main file in the health centre.
Client name	Name of client receiving DOT.
Phone Number	Client's phone number; or number where a message can be safely left.
Date of Birth	Client's date of birth (birth year, month, date)
Gender	Self explanatory
Band #	The ten-digit treaty status number.
PHN	The client's personal health number.
Address	Clients house address &/or direction to house
Medication Prescription	List drugs and dosage ordered by TB Control. Start new record when/if medications or dosages change.
Incentives/Enablers	List items or helpful hints to encourage and support compliance (e.g. apple juice, stickers, pudding, etc.).
Date	Date of visit for DOT. This date refers to the entire column.
Side Effects	At each visit observe and check if client has any of these complaints. Document your findings. If no signs or symptoms use N. If yes, mark Y under the correct date to show which complaint was present. If additional space is needed to explain, use field notes. Report any side effects to supervising nurse & **hold** medication until advised by nurse. Side effects listed at the bottom of this list are for specific drugs as indicated in brackets. (Note: ETH = Ethambutol; INH = Isoniazid)
Notes	Mark Y if field notes used.
Nurse notified	Under correct date, mark Y when nurse is notified.
Watched Client Swallow Pills	If no side effects, give medication and observe dose being swallowed. Under correct date, mark Y when client was observed swallowing pills.
Time	Under correct date, write time of day dose was swallowed.
DOTW Initials	Under correct date, enter initials of worker who observed the client.
Nurse Review Initials	Nurse records initials each time client or client file is reviewed. Each client should be assessed by a nurse at least monthly.
Follow up Tests/Reminders	Indicate date test is due and check box when requisition is given and check box when test completed.
Initial/Signature/Designation	Enter legible initials, signature and working title of all DOTWs, CHRs and nurses working with this client.