THE UNITED REPUBLIC OF TANZANIA

Ministry of Health

National Tuberculosis and Leprosy Programme

DR-TB DAILY DOT RECORD

First Name _____Middle Name _____Surname:_____
Facility _____ Council_____ Treatment Month._____
Body Weight /Date ____/____/_____

DR-TB TREATMENT REGIMEN

Drug	Dosage	Frequency	Date started	Date Stopped
Levofloxacin/Moxifloxacin				
Linezolid				
Bedaquline				
Cycloserine				
Clofazimine				
Pyrazinamide				
Delamanid				
Ethionamide/Prothionamide				
Paraminosalycylic Acid				
High Dose Isoniazid				
Ethambutol				
Amikacin				
Stretomycin				
Pretomanid				
Pyridoxine				

	Side Effect Codes
1	Abdominal pain
2	Constipation
3	Decreased hearing
4	Depression
5	Diarrhea
6	Dizziness
7	Fatigue
8	Jaundice
9	Headache
10	Joint pain
11	Nausea/vomiting
12	Psychosis
13	Insomnia
14	Numbness/Tingling sensation

DAILY DOT RECORD: Record numbers of pills or cc's given and write your initials under DOT initials. Mark "R" if patient refused medication. Mark "H" if medication was held.

Day	Mfx/ Lfx	Lzd	Bdq/ Dlm	Cs	Clz	Z	Eto/Pto		PAS	Hd INH	E	Am	S	Pa	Vt V6	DOT Initials		SE
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