UDOH TB Control Program
DOT Calendar Log

Patient Name: _____ *Address:* _____

Birth date: _____ *Phone:* _____ *Site of DOT:* _____

Special Instructions: _____

In boxes: initial days DOT witnessed; place 'P' if packet given; or '0' if appt is missed & state why on back of form.

May 2007

Sun	*Mon*	*Tue*	*Wed*	*Thu*	*Fri*	*Sat*
		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		

June 2007

Sun	*Mon*	*Tue*	*Wed*	*Thu*	*Fri*	*Sat*
					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

July 2007

Sun	*Mon*	*Tue*	*Wed*	*Thu*	*Fri*	*Sat*
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				

Aug 2007

Sun	*Mon*	*Tue*	*Wed*	*Thu*	*Fri*	*Sat*
			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	

MEDICATION	DOSAGE	FREQUENCY	START DATE	STOP DATE

DOT Worker Name & Initials

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Treatment completed: _____