Iowa Department of Public Health
Tuberculosis Control Program DOT Log

DOT: ___ $900
Other ___ Amount $_____

Name (Last, First):				**DOB (D/M/Y):**			
Street Address:			**City:**	**Med/Strength**	**Dose/# tabs**	**Start Date**	**End Date**
Phone (home/work/ cell):			**Zip:**				
Date:	**Printed Name:**	**Signature:**	**Initials:**	**DOT Start Date:**			
				DOT End Date:			
				DOT Site: ☐ Home ☐ Work			
				☐ Clinic ☐ Other_____			

Day of Month	Dose #	eDOT	DOT	SELF-ADMIN	Initials of DOT Personnel	Side Effects: If present, check and write progress note. If absent, check in the "none" column.														
						None	Nausea/ Vomiting	Abdominal Pain	Headache	Loss of Appetite	Jaundice	Numbness/ tingling	Rash	Fatigue	Joint Pain	Vision Change	Hearing Change	Other	Dr. Notified of adverse reaction	Comments
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