Royal College of Nursing

MDR DOT/VOT (Form: 5)

Form 5: MDR DOT/VOT (complete this form for every person commencing MDR DOT/VOT TB treatment for active disease) clinic;

NHS no.	Hospital no:	Case manager:	Consultant:	Assessment Date: / /
Last name:	Other names:		LTBR / ETS no:	DOB: / /
Treatment key: **given/ DNA/ self ad.**	DOT treatment start: / /	Estimated date change to therapy: / /	Estimated treatment completion date: / /	

TB Medication:	Dose:	Dose:	Dose:	Dose:	Dose:	Dose:	Dose:		Dosage date: / / Signature/designation:	
Date/time: (dd/mm/yy - hh:min)	Frequency:	Frequency:	Frequency:	Frequency:	Frequency:	Frequency:	Frequency:		**HCW Sig.**	**Patient Sig.**

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Form 5: Continuation Sheet (notes relevant to TB treatment) Name Hospital no.

Date/time:	Notes:	Signature:

Month _____ Year_____
Doses observed: _____
Doses self administered _____
Doses missed: _____
Observed doses taken (%) _____

Action: _____
_____
_____
_____
_____

Date: ____/____/_____ Signature: _____ Name: _____ Designation: _____

Source:
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