DIRECTLY OBSERVED THERAPY FOR THE MONTH OF:

PHYSICIAN:

DATE	INI	MEDICATION	DOSAGE	RTE	FREQ	DATE	INI	WEEKEND MEDICATION	DOSAGE	RTE	FREQ

NAME:

ADDRESS:

SCHOOL:

TELEPHONE: DOB: AGE:

DIAGNOSIS:

DOT START: DOT DISCONTINUED:

SIDE EFFECTS:
IF PRESENT, CHECK AND WRITE DISPOSITION UNDER COMMENTS
IF ABSENT, CHECK NONE BOX

PATIENT COMPLAINTS

DATE	DAY	SIGNATURE OF PERSON OBSERVING OR GIVING MEDICATION	TIME MEDS OBSERVED	COMMENTS	PHYSICIAN NOTIFIED OF ADVERSE REACTION	Nausea	Abdominal Pain	Headache	Loss of Appetite	Jaundice/Yellow color	Rash	Fatigue	Joint Pain	Vomiting	Others	None

Meds taken (# of days) _____ X 100 = Adherence rate _____%
Available Days