

**Fax to:**

Vancouver TB Control: 604-707-2690

New West: 604-707-2694

**RECORD OF SUPERVISED TB MEDICATION(S) FOR THE MONTH OF:** \_\_\_\_\_ **20** \_\_\_\_\_

**HEALTH UNIT:** \_\_\_\_\_

**SURNAME:** \_\_\_\_\_

**GIVEN NAME(S):** \_\_\_\_\_

**GENDER:** \_\_\_\_\_ **TB NUMBER:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

YYYY / MM / DD

**DELIVERY METHOD CODES:**

- H – Home Visit
- T – Treatment Facility visit (to a clinic, office or health facility)
- X – Patient did not keep appointment or not found on home visit
- N – No medication given

*Record in calendar the method used to supply the patient & the medication*

<b>Isoniazid tablets 300 mg</b> Dosage: _____ mg each time Frequency: _____	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		
<b>Pyridoxine (Vitamin B6) tablets 25 mg</b> Dosage: _____ mg each time Frequency: _____	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		
<b>Rifampin capsules 300 mg</b> Dosage: _____ mg each time Frequency: _____	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		
<b>Pyrazinamide tablets 500 mg</b> Dosage: _____ mg each time Frequency: _____	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		
<b>Ethambutol tablets 400 mg</b> Dosage: _____ mg each time Frequency: _____	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		
<b>Isoniazid Syrup 10 mg/mL:</b> Dosage: _____ mg each time Frequency: _____	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		

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<b>Drug:</b> _____ Dosage: _____ mg each time Frequency: _____	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	
<b>Drug:</b> _____ Dosage: _____ mg each time Frequency: _____	1	2	3	4	5	6	7	8	9	10	11
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	12	13	14	15	16	17	18	19	20	21	
	22	23	24	25	26	27	28	29	30	31	

**Patient Name:** \_\_\_\_\_

**Health Care Provider:** \_\_\_\_\_  
PLEASE PRINT

**Signature:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

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Medications not required