North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section

Tuberculosis Drug Record

1. Last Name	First Name		MI
2. Patient Number			
3. Date of Birth (MM/DD/YYYY)	Month	Day	Year
4. Race ☐ 1. American Indian/Alaska Native ☐ 2. Asian ☐ 3. Black/African American ☐ 4. Native Hawaiian/ Other Pacific Islander ☐ 5. White ☐ 6. Unknown			
Ethnicity: Hispanic or Latino Origin? ☐ Yes ☐ No ☐ Unknown			
5. Gender ☐ 1. Female ☐ 2. Male			
6. County of Residence			

DRUG ORDERS				
Drug	Dosage	Date Ordered	Prescription #	Date D/C
INH				
RIF				
PZA				
EMB				

Date Drug Given	INH			RIF			PZA			EMB						
	No. Tabs	Mg	Refill Due	No. Tabs	Mg	Refill Due	No. Tabs	Mg	Refill Due	No. Tabs	Mg	Refill Due	No. Tabs	Mg	Refill Due	Given By

Remarks: _____

Treatment Observer(s)

Initials	Print Name	Signature

Directly Observed Daily or Intermittent Drug Therapy Record

Patient's Name _____ DOB _____

Drug	Dosage	Frequency	Date Started	Date Stopped
INH				
RIF				
PZA				
EMB				

Sputum Conversion Date: _____ Reason for prolonged therapy (if indicated):_____

Place initials on date meds are observed being ingested. Use key if full dose not observed. **Initial Weight:**

Month	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Month
Year													**Year**
1													1
2													2
3													3
4													4
5													5
6													6
7													7
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31													31

DHHS 1391 (Revised 06/2017)
TB Control (Review 06/2020)

Key: Self Administered: (S) Vomited: (V) Held: (H)
Missed Dose: ◯ Partial Dose During Reintroduction: (P)