**Überwachungstabelle für die direkt überwachte Medikamenteneinnahme (DOT) zur Behandlung der Tuberkulose**

Bitte dieses Formular am Monatsende oder bei Transfer an die Lungenliga … zurücksenden.

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| Name, Vorname | |  | | | Geburtsdatum | | |  | | |
| Therapiebeginn | |  | | | | | | | | |
| Arzt/Ärztin | |  | | | Adresse | | |  | | |
|  | | | Telefon | | |  | | |
|  | | | | | | | | | | |
| **Medikamente** | | | **Datum** | **Dosis** | | | **Morgen** | **Mittag** | **Abend** | **Stoppdatum** |
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| **Medikamentenabgabe im** ........................... (Monat) | | | | | | | | | | |
| **Datum** | **Visum** | **Befinden/Spezielles** | | | **Datum** | **Visum** | | **Befinden/Spezielles** | | |
| 1. |  |  | | | 16. |  | |  | | |
| 2. |  |  | | | 17. |  | |  | | |
| 3. |  |  | | | 18. |  | |  | | |
| 4. |  |  | | | 19. |  | |  | | |
| 5. |  |  | | | 20. |  | |  | | |
| 6. |  |  | | | 21. |  | |  | | |
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| 11. |  |  | | | 26. |  | |  | | |
| 12. |  |  | | | 27. |  | |  | | |
| 13. |  |  | | | 28. |  | |  | | |
| 14. |  |  | | | 29. |  | |  | | |
| 15. |  |  | | | 30. |  | |  | | |
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