**Tableau de contrôle pour la prise de médicament sous contrôle direct (DOT), dans le traitement de la tuberculose**

Veuillez retourner ce formulaire à la fin de chaque mois ou lors d’un transfert, à la Ligue pulmonaire du canton de ....

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| Nom, Prénom | | |  | | | | Date de naissance | | | |  | | | | |
| Début de la thérapie | | |  | | | | | | | | | | | | |
| Médecin | | |  | | | | Adresse | | | |  | | | | |
|  | | | | Téléphone | | | |  | | | | |
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| **Médicaments** | | | | **Date** | **Dosage** | | | | **Matin** | | | **Midi** | **Soir** | **Date d’arrêt** |
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| **Médicaments remis en ………………………(mois)** | | | | | | | | | | | | | | | | |
| **Date** | | **Visa** | | **État de santé/Remarques** | | | | **Date** | **Visa** | | | **État de santé/Remarques** | | | | |
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