TEXAS DEPARTMENT OF HEALTH
D.O.T. ORDER FORM
512/458-7500; FAX-512/458-7489
PHYSICIAN _____ DATE _____
Expert TB Consultant _____ DATE _____
(Consult for LEVOFLOXACIN required)

CLINIC: _____
ADDRESS: _____
_____
ATTN: _____
PHONE: _____

PATIENT ORDERS ***PACKETS*** ***PHARMACY USE ONLY***

PATIENT NAME _____ DRUG STRENGTH AMT 1. 2. 3. 4. 5. 6.		
PATIENT NAME _____ DRUG STRENGTH AMT 1. 2. 3. 4. 5. 6.		
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