Consent and Treatment Plan for Latent Tuberculosis Infection (LTBI) With Directly Observed Therapy

I, _____, have been advised and counseled by _____.
(Client's Name) (Public Health Representative/Title)

Based on available information, I (may) have latent tuberculosis infection (LTBI). The following has been explained to me:

1. LTBI means I have been infected by the TB germ M. tuberculosis. My immune system has walled off the germs to keep them dormant (sleeping). I have no symptoms and cannot spread the germ to others.

2. Without treatment, I can get sick with active TB disease and have symptoms such as cough, fever, night sweats, weight loss or extreme tiredness. If any of these symptoms appear, I agree to call the health department at _____ immediately.

3. I understand the link between TB and HIV and therefore I agree to be tested for HIV.

4. I agree to take my TB medication, as ordered via DOT for the entire length of treatment. I agree to cooperate with the supervised DOT program to help remind me to take my medicine and to make sure I complete my treatment. In this program, a designated public health employee or a trained DOT worker is authorized as my agent to maintain possession of my medication and to be present when I take my TB medicine.

5. I will be at: ___ home ___ work ___ clinic/lhd ___ other (specify) _____ between the hours of _____ and _____ for my DOT visit. If I cannot meet at the agreed place/time, I will call _____ at _____ to change the visit. If I do not call in time to change the visit, I know that I may have to go to _____ between _____ for my DOT visit.

6. I will notify the health department if I am unable to take my medication for any reason.

7. The side effects of the medication I am taking have been explained to me. I agree to call the health department at _____ immediately if I develop any of these side effects.

8. I agree to tell the health department if I move or change my phone number. I agree to tell the health department how to reach me in person and by telephone.

9. My treatment plan has been explained to me and all my questions have been answered. I have a copy of this plan.

_____ _____
Client's Signature Date Public Health Representative/Title Signature Date

_____
Witness/Interpreter's Signature Date

Affix Patient label or complete:

Name _____
Address _____
_____
City, State, Zip _____
Telephone _____
Patient ID# _____