Consent to and Treatment Plan for Latent Tuberculosis Infection

Form 3609.LTBI (revised 10/2016)

I, _____, have been advised and counseled by _____
(patient's name) (Public Health Representative/Title)

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

- ❑ 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 can not spread the germ to others.
- ❑ I know that 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.
- ❑ I understand the link between TB and HIV and therefore, I agree to be tested for HIV.
- ❑ I agree to follow this treatment plan. I agree to come to the health department for medical evaluations and medication refills as prescribed. I agree to cooperate during my treatment. If I am unable to keep a scheduled appointment, I will call the health department at once and reschedule another appointment within 7 days.
- ❑ I agree to take my TB medication as ordered for the entire length of treatment. I will notify the health department if I am unable to take my medication for any reason.
- ❑ 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.
- ❑ 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.
- ❑ My treatment plan has been explained to me and all my questions have been answered. I have a copy of this plan.

Patient signature _____ Date _____

Public Health Representative Signature _____ Date _____
Public Health Representative Title _____

Witness/Interpreter Signature _____ Date _____

Affix Patient label or complete:

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