Consent to Treatment for Active Tuberculosis Disease

Form 3609.TB (revised 10/2016)

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

that based on available information, I may have/have active tuberculosis (TB) disease. The following has been explained to me:

- ❑ TB is an infectious disease that can be spread to others. I know that I need to be away from other people until I can not spread the disease to them. I know that untreated TB can lead to drug resistant disease or may be fatal. I need to take TB medicines for many months to get well.
- ❑ I agree to be treated for TB and to help with identifying any persons that could have been exposed to TB by me in order to prevent my family, friends or co-workers from getting sick.
- ❑ I understand the link between TB and HIV and therefore, I agree to be tested for HIV.
- ❑ I agree to follow the treatment plan given to me by my health care provider and the health department.
- ❑ If I do not follow my treatment plan, legal action can be taken against me.
- ❑ I have a copy of my treatment plan and all my questions have been answered.

Patient's 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# _____