Directly Observed Therapy Agreement for Tuberculosis Treatment

Form 603 (revised 10/2016)

Patient Name _____ Date of Birth _____ Home phone _____
Patient Address _____ Work phone _____
City _____ ZIP _____ Cell phone _____
Emergency Contact Person Name _____ Telephone _____
Health Department _____ Date _____

I _____ understand and agree that:
(patient's name)

- ❑ The only way to get well is by taking my tuberculosis (TB) medicine exactly as my nurse or doctor tells me. If I do not follow these directions, my illness could come back worse than before. Then it could be harder to treat, take longer to treat and/or could spread the disease to others.
- ❑ I will be taking several medications for a long time (6 months or more) in order to kill the TB germs.
- ❑ I agree to cooperate with the supervised Directly Observed Therapy (DOT) program to help remind me to take my medicine and to make sure I complete my treatment and get well. 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.
- ❑ I will be at: ____Home ____Work ____Clinic/Health Department ____ Other_____ between the hours of _____ and _____ for my DOT visit.
- ❑ If I cannot be at the agreed place and 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.
- ❑ I will tell my DOT worker if I have any problems. I may be asked to go to _____ to meet with a doctor or nurse and/or to have tests during my treatment.
- ❑ I know that if I miss my visits and do not take my treatment as scheduled, legal action may be taken.

I, _____ understand and agree that:
(Name of Public Health Representative/Title)

- ❑ If I cannot be at the agreed place and time, I will call _____ at _____ to change the visit.
- ❑ I will keep the patient's health data private.
- ❑ I will answer questions and concerns of the patient. I will help link the patient to other services as needed.
- ❑ I will promptly tell the doctor and/or nurse of anything out of the ordinary. I will give reports as needed.

Patient Signature _____ Date _____

Public Health Nurse Signature _____ Date _____

DOT Provider Signature _____ Date _____