TB PREVENTION AND CONTROL
Georgia Department of Public Health

Consent to and Treatment Plan for Latent Tuberculosis Infection with Directly Observed Therapy Form 603.LTBI (revised 01/2020)

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

Based on available information, I have/may 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 cannot spread the germ to others.
- ❑ 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 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.
- ❑ I will be at: ___ home ___work ___ clinic/HD ___ 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.
- ❑ 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/Title Signature _____ Date _____

Witness/Interpreter Signature _____ Date _____

Affix Patient label or complete:

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