TB PREVENTION AND CONTROL
Georgia Department of Public Health

Video Observed Therapy Agreement for Latent TB Infection Treatment

Form 603.VDOT.LTBI (created 01/2020)

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 name)

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 will be taking medications for a long time (4 months or more) in order to kill the TB germs.
- ❑ I agree to cooperate with the Video Directly Observed Therapy (VDOT) program using Telehealth Webex application 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/transport my medication (if/when necessary) and to be present (electronically) in order to view me when I take my TB medicine.
- ❑ I understand that Webex is HIPAA compliant so my personal information is private and secure. End-to-end encryption is used to ensure that my information is kept private and no information or video is recorded and stored. This technology is free to me but I must use my own cell phone, computer (or other electronic device) and internet in order to participate in the program.
- ❑ I will be available for my VDOT appointment between _____ and _____.
- ❑ If I cannot make my VDOT appointment at the agreed time, I will call _____ at _____ to change the time of the appointment.
- ❑ If I do not call in time to change the VDOT appointment, I know that I may have to go to _____ between _____ and _____ 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.
- ❑ VDOT is voluntary and I can choose to use traditional face-to-face Directly Observed Therapy at any time.
- ❑ VDOT may be stopped if I miss more than one scheduled VDOT appointment in a week, miss a scheduled clinic appointment, have any reaction(s) during my treatment and require physician evaluation, have any adverse reactions to my medications, my equipment (cell phone, computer, etc) is lost, stolen, or damaged, my condition worsens or I am physically unable to participate in VDOT.

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

- ❑ If I cannot call in for the VDOT appointment at the agreed time, I will call _____ at _____ to change the appointment time.
- ❑ 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/Interpreter Signature _____ Date _____