DPH Georgia Department of Public Health TB PREVENTION AND CONTROL

Video Observed Therapy Agreement for Active Tuberculosis Disease Treatment

Form 603.VDOT.TB (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)

- ❑ 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 understand the link between TB and HIV and therefore I agree to be tested for HIV.
- ❑ I agree to cooperate with the Video Directly Observed Therapy (VDOT) program using Telehealth Webex application 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/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 perform VDOT.
- ❑ I know that if I miss my VDOT appointments, clinic visits/appointments 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 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 _____