

# Consent to Treatment

## Active TB Case/Suspect

I, \_\_\_\_\_, have been told by  
(Client's name)

\_\_\_\_\_ that based on available information, I (may have  
(Public Health Representative/Title)

/ have) active tuberculosis (TB) disease. The following has been explained to me:

1. 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.
2. I agree to be treated for TB and to help with the contact investigation to prevent my family, friends or co-workers from getting sick.
3. I understand the link between TB and HIV and therefore I agree to be tested for HIV.
4. I agree to follow the treatment plan given to me by my health care provider and the health department.
5. If I don't follow my treatment plan, legal action can be taken against me.
6. I have a copy of my treatment plan and all my questions have been answered.

\_\_\_\_\_  
(Client's Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Public Health Representative/Title)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness/Interpreter's Signature)

\_\_\_\_\_  
(Date)

Affix Patient label or complete:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Telephone \_\_\_\_\_  
Patient ID# \_\_\_\_\_