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Patient Label

TUBERCULOSIS CLINIC
INFORMED CONSENT for
DIRECTLY OBSERVED PREVENTIVE THERAPY

To: _____ **D.O.B.:** _____
Patient Name

Address: _____

_____

Contact Phone: _____

I, _____ have been
(Name of Patient)

informed that I have been diagnosed with an in-active form of tuberculosis infection. This infection and the medication(s) required to treat it have been fully explained to me and my questions fully answered. Therefore, to the best of my ability, I understand that this tuberculosis non-infectious condition is a very serious and could lead to contagious disease if left untreated.

Therefore, I do fully agree to and intend to be compliant with my regimen of treatment for in-active tuberculosis infection, as prescribed by the _____Health Department medical provider in the Tuberculosis Clinic, or by my own personal physician.

It is very important that I follow the physician's orders to prevent active infectious form of tuberculosis (TB). Therefore, I am being placed in a supervised treatment program by your physician and the county.

This program requires that I take my TB medicines while being observed by the public health nurse or other designated person as indicated below (e.g., location, days, and time):

Location: _____

Days: Monday Tuesday Wednesday Thursday Friday

Time: _____AM / PM

*(*On Friday, a package of TB medicines for Saturday and Sunday will be left for you to take on the appropriate day if treatment doses are given seven days a week)*

I do further agree to Direct Observed Preventative Therapy (DOPT) in person and on a daily basis by _____Health Department TB Clinic Outreach Nurses, or on an alternate schedule of DOPT as prescribed by the _____Health Department medical provider, and to come to the Tuberculosis Clinic monthly and/or as needed to be evaluated by a medical provider or registered nurse for the status of my condition.

Tuberculosis Prevention and Control Staff Person Signature	Date
Designated Person	Date

I have read the above information, understand it, and agree to the conditions.

Patient's Signature	Date
Interpreter Signature	Date