**Consent Form for Video-Directly Observed Therapy (V- DOT)**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am aware that I have been diagnosed with tuberculosis (TB). I will need a long course of medication to treat my tuberculosis. It is the current standard of care in Kentucky for all doses of TB medications to be taken with directly observed therapy (DOT) in order to insure patient compliance with therapy. Observation of taking medication doses is normally done in the patient’s home or at the Local Health Department (LHD). A patient must complete eight (8) weeks of DOT without any compliance concerns before V-DOT can be considered.

During my treatment, I agree to work with the (LHD) to have video observation of my doses to be performed using my Smartphone or camera connected to my computer.   
  
Type of V-Dot (Please check one below)

□ FaceTime □ SightSpeed □ VBuzzer   
□ iChat □ Skype □ Viber   
□ Google Hangout □ TinyChat □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I will be using my Smartphone or a camera connected to my computer in:  
□ my home or □ pre assigned location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Time).

on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (List days of week)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree to allow the Local Health Department worker to watch me take my medicines over the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (type of V-DOT) at the prearranged time either daily, twice, or three times per week.

I understand that I may switch back to standard in-home DOT at any time during the treatment. The use of   
V-DOT technology may have certain benefits to me. It is hoped that V- DOT will be less intrusive and allow greater flexibility in time of therapy. The use of V-DOT technology is not believed to carry any risk for the patient.

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 Signature of Patient Printed Name of Patient Date

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 Signature of (LHD) Official Printed Name of (LHD) Official Date