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Patient Label

**TUBERCULOSIS CLINIC**

**INFORMED CONSENT for DIRECTLY OBSERVED THERAPY**

**To:** **D.O.B.:**

Patient Name

**Address:**

**Contact Phone:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have been

(Name of Patient)

informed that I have been diagnosed with an active case of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

tuberculosis. This disease 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 tuberculosis is a very serious and contagious disease and could be easily transmitted to those with whom I come into close contact, even on a casual basis.

Therefore, I do fully agree to and intend to be compliant with my regimen of treatment for tuberculosis, 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 so that I am cured 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)*

Failure to do so on my part will result in, according to Kentucky Law KRS 215.560 AND 215.570, a warrant for my arrest being served by the police department and confinement, under guard, either in an appropriate hospital or the county jail until such time that I am to be no longer infectious to the general public and my family and friends.

I do further agree to Direct Observed Therapy (DOT) in person and on a daily basis by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Health Department TB Clinic Outreach Nurses, or on an alternate schedule of DOT 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