

Direct Observed Therapy Agreement
Virginia Department of Health * Tuberculosis Control

Client _____ DOB _____

Address _____ Health District _____

City _____ ZIP _____ Phone _____

The Directly Observed Therapy (DOT) program has been explained to me; I understand that taking this medication is the most effective way to kill TB bacteria. I agree to have a tuberculosis (TB) worker watch me take TB medicine according to the plan ordered by my doctor.

I, _____ understand and agree to the following:
Name of Client

1. I will be at: ___ Home ___ Work ___ Clinic/LHD ___ Other (specify) _____
between the hours of _____ and _____ to receive my tuberculosis medicine.

2. If, for any reason, I cannot be present to take my medicine at the normal place and time, I will call
_____ at _____ to change the appointment.
Name of Person Phone Number

3. If I do not call to change the appointment or call too close to the scheduled time, I understand that I may
have to go to _____ before the end of the day to take my medicine.
Name/Address of place

4. I will tell my DOT worker of any complaints, questions or problems that I have. I understand that if I am
having side effects to the medicine, I may be asked to go to _____ to meet with a
doctor or nurse and may have laboratory tests. Name of place

5. I understand that if I miss my appointments and do not take my medicine regularly, legal action maybe
taken.

6. The _____ agrees to provide the following:
Name of Health District/Case Manager

- The DOT assignee will observe medication doses being taken at the assigned location during the time period arranged. If the DOT worker needs to change the appointment time or place, every effort will be made to give the client advance notice of any necessary changes.
- The DOT assignee will maintain client confidentiality.
- The DOT assignee will respond to all questions and concerns raised by the client.
- The DOT assignee will assist with referrals to other service agencies as appropriate.
- The DOT assignee will immediately notify the Case Manager of client concerns and provide feedback as necessary.

Client Signature

ORW Name

Nurse Case Manager Signature

Date