Direct Observed Therapy Agreement

Patient Label

The Directly Observed Therapy (DOT) program was explained to me. I understand that taking this medication is the best way to kill the TB germ. I agree to have a tuberculosis (TB) worker watch me take my TB medicine.

I, _____understand and agree that:
Client Name

1. I will be at: _____Home _____Work _____Clinic/LHD _____Other (specify)_____ between the hours of _____ and _____ to take my TB medicine.

2. If I cannot take my medicine at the normal place and time, I will call _____ at _____to make other plans.
Name of Person Phone Number

3. If I do not call to make other plans, I will go to _____ before the end of the day to take my medicine. Name/Address of place

4. I will tell my DOT worker if I have any problems taking my medicine.

5. I know that if I miss my appointments and do not take my medicine as ordered, legal action can be taken (not applicable for latent TB infection regimens).

6. The _____agrees that the DOT worker:
Name of Health District and Case Manager

   - Will watch you take your medicine at the agreed place and time.
   - Will tell you in advance if your appointment needs to change.
   - Will keep your information private.
   - Will answer your questions and concerns.
   - Will make sure your case manager knows about your concerns.

_____ _____
Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis

DOT Worker Name

_____ _____
Nurse Case Manager Signature

Date

_____
Interpreter Name/ID Number