Direct Observed Therapy Agreement

Name: _____

Address:_____

_____

Phone: _____ DOB_____

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

I, _____understand and agree that:
Client Name

1. 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.

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

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

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

5. I will maintain clear communication with my TB DOT worker and let them know if I have any problems with the medicine or with the agreed upon schedule.

6. 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) and those doses would not count towards my planned treatment length.

7. I will notify my TB DOT worker or Case Manager **before** any travel plans are made so we can work together and plan how I will take my medicine.

_____ _____

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

DOT Worker Name

_____ _____

Nurse Case Manager Signature

Date

_____

Interpreter Name/ID Number