ACTIVE TUBERCULOSIS (TB) TREATMENT PLAN

Local Health Department:	Telephone:	Name of LHD Contact:

Health care provider will check the appropriate instructions. The client will initial checked instructions.

☐ **I understand I (may have/have) active tuberculosis disease and that I need to take TB medications for an extended period of time. I may need to take medications longer than initially told if my clinical condition changes. _____ (client initials)**

- ☐ I agree to take my medication as ordered. I will call the health department if I am unable to take my medication for any reason. Directly Observed Therapy (DOT) has been explained to me and I have signed a DOT agreement. _____
- ☐ The side effects of my medication have been explained to me and I agree to call the health department immediately if I develop any of the side effects. _____
- ☐ I agree to keep all clinic appointments. If I am unable to keep an appointment, I will call the health department and reschedule another appointment within 7 days. _____
- ☐ I agree to provide sputum, urine, or blood specimens as requested. _____
- ☐ I agree to tell the health department of any changes in my health. _____
- ☐ I agree to tell the health department if I move or change my phone number. I agree to tell the health department how to reach me in person and by telephone. _____

☐ **I am infectious and can spread the disease to others. _____ (client initials)**

- ☐ I will remain at home on isolation. As much as possible, I will stay away from other people in my house by staying in my room or wearing a surgical mask when I leave the room. I understand separate bedrooms or beds are highly recommended. _____
- ☐ I will cover my mouth and nose with a tissue when I cough or sneeze. These tissues should be flushed, burned or placed in a sealed leak proof bag before disposal. _____
- ☐ I understand that my activities are limited. I will not travel, go to work, go to school, go shopping, or participate in any other activity where I will be in contact with other people. _____
- ☐ I agree not to leave my home except to keep medical appointments. I agree to wear a surgical mask to the clinic and the doctor's office. _____
- ☐ I will not allow anyone, other than those living with me or those individuals providing care to me, into my home and I will stay away from young children. _____
- ☐ I understand that at any point during my treatment phase, isolation instructions may become effective if my clinical status changes and it is determined I am infectious. _____
- ☐ I understand these isolation instructions remain in effect until I am told by the health department that I no longer have to stay in isolation. _____
- ☐ I agree to help with the contact investigation by sharing the places I have been and the names of the people I have been around to prevent my family, friends, or co-workers from developing this disease. _____

☐ **I understand the reasons I need to complete my treatment and that legal action can be taken against me if I fail to follow my treatment plan. _____ (client initials)**

I have received a copy of this treatment plan. It has been explained to me and all my questions have been answered. I agree to follow this treatment plan.

Signature of Client _____ Date: _____/_____/_____

Signature of Public Health Representative_____ Date: _____/_____/_____