CONSENT AND TREATMENT PLAN FOR LATENT TUBERCULOSIS INFECTION (LTBI)

Patient Name:	DOB:	Phone:
Address:	City:	Zip:
Emergency Contact Person:	Phone:	Date:

I, _____ (Name of Client) have been advised and counseled by _____ (Name of Public Health Nurse) that based on available information I, may have/have latent tuberculosis infection (LTBI). The following has been explained to me:

1. A LTBI diagnosis means that I have been infected by the TB germ *M. tuberculosis*. My immune system has confined the bacteria to keep them dormant. I have no symptoms and cannot spread the bacteria to others.
2. I know that without treatment, I can get sick with active TB disease and have symptoms such as cough, fever, night sweats, weight loss or extreme tiredness. If any of these symptoms appear, I agree to call the health department immediately.
3. I understand the link between TB and HIV and therefore I agree to be tested for HIV.
4. I agree to follow this treatment plan. I agree to come to the health department for medical evaluations and prescription refills as ordered and to cooperate in my treatment. If I am unable to keep a scheduled appointment, I will call the health department at once and reschedule another appointment within 7 days.
5. I agree to take my TB medication as ordered for the entire length of treatment. I will notify the health department if I am unable to take my medication for any reason.
6. The side effects of the medication I am taking have been explained to me. I agree to call the health department at _____ (phone number) immediately if I develop any of these side effects.
7. 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.
8. My treatment plan has been explained to me and all my questions have been answered. I have a copy of this plan.

Client Signature: _____ Date: _____/_____/_____

Public Health Nurse: _____ Date: _____/_____/_____

Witness/Interpreter's Signature: _____ Date: _____/_____/_____