DIRECTLY OBSERVED THERAPY (DOT) AGREEMENT FOR TUBERCULOSIS (TB) TREATMENT

IDPH
Illinois Department of Public Health

Patient Name:	DOB:	Phone:
Address:	City:	Zip:
Emergency Contact Person:	Phone:	State Case Number:

Directly Observed Therapy (DOT), or supervised therapy, involves direct visual observation by a health care provider (e.g., public health nurse, outreach worker, nurse, nurse's aide) or other reliable trained person (e.g., worker in a homeless shelter) of a patient's ingestion of medication. Delivering medication to a patient without visual confirmation of ingestion does not constitute DOT. However, a live video camera confirmation of ingestion of medicine of **carefully selected patients** (e.g., stable and compliant) constitutes DOT.

I, _____ (Name of Client) **understand and agree that:**

1. The only way to get well is by taking my TB medicine exactly as my nurse or doctor advises me to do. If I do not follow these directions, my illness could come back worse than before. Then it could be harder to treat, take longer to treat, and could spread the disease to others.
2. I will be taking several medications for a long time (6 months or more) in order to kill the TB bacteria.
3. I agree to cooperate with the supervised DOT program staff who will help remind me to take my medicine and to make sure I complete my treatment and get well. In this program, a designated public health employee or a trained DOT worker is authorized as my agent to maintain possession my medication and to be present when I take my TB medicine.
4. I will be at: ❒ Home ❒ Work ❒ Clinic/LHD ❒ Other – Specify _____ between the hours of _____(time) and _____(time) for my DOT visit.
5. If I cannot be at the agreed place and time, I will call _____ (name of DOT worker) at _____ (phone number) to reschedule the visit.
6. If I do not call in time to change the visit,
   a. I will tell my DOT worker if I have any problems. I may be asked to meet with a doctor or nurse and/or to have tests during my treatment.
   b. I know that if I miss my visits and do not take my treatment as scheduled, legal action may be taken.

I, _____ (Name of PH Nurse) **understand and agree that:**

If I cannot be at the agreed place and time, I will call _____ (client name) at _____ (phone number) to reschedule the visit.

1. I will keep the client's health data private.
2. I will respond to questions and concerns of the client. I will help link the client to other services as needed.
3. I will promptly tell the doctor or nurse of anything out of the ordinary. Will give reports as needed.

Client Signature: _____ Date: _____/_____/_____

Nurse Signature: _____ Date: _____/_____/_____