



343-NonDOH December 2014

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ACKNOWLEDGEMENT OF TUBERCULOSIS COUNSELING

I, _____, have been advised and counseled by
(Client's Name)

_____ regarding tuberculosis.
(Public Health Designee's Name)

The following has been explained to me:

- Tuberculosis (TB) can spread to others through the air.
- Without treatment, TB can cause severe illness, permanent disability, and death.
- TB treatment usually requires at least 6 months. In some cases, it might require 12 months or longer.
- I must take TB medications for my health and the health of others. It is so important that there is an outreach worker assigned to deliver those medications to me and observe me taking them (Directly Observed Therapy).
 - ✓ I may choose where I get Directly Observed Therapy (for example, home, work, or the TB Clinic).
 - ✓ It is my responsibility to be available for Directly Observed Therapy.
- I will be considered infectious until the TB Control Program informs me that I am no longer infectious. Even after I am no longer infectious and no longer feeling ill, I must complete the entire course of treatment to be cured.
- While I am considered infectious, it is important to isolate myself until the TB Control Program gives me clearance. This is to avoid spreading TB to other people.
 - ✓ I need to stay in the place of residence approved by the TB Control Program.
 - ✓ I must not change my place of residence without obtaining approval from the TB Control Program.
 - ✓ While I am in isolation, I agree to see only persons who have been cleared by the TB Control Program.
 - ✓ If I have to see anyone who has not been cleared by the TB Control Program, I must see them out of doors.
 - ✓ I should not visit homes of others, churches, schools, work places, or other public or private places where I would be in contact with other persons.
 - ✓ If I need to go to a store, a laundry, or a medical facility, or use a bus or a taxi because of special circumstances, I must obtain an approval from my nurse case manager and I must wear a mask provided by the TB Control Program and limit my presence with other people to less than 60 minutes.

*** This is a permanent part of the health record ***

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Tuberculosis Control Program
Public Health – Seattle & King County
Harborview Medical Center
325 9th Ave. PO Box 359776
Seattle, WA 98104
Phone: 206.731.4579
FAX: 206.731.4350

Client Name:

HR#:

D.O.B.:

- I agree to follow medical evaluations to make sure that my TB is getting cured and I am not having side effects from TB medications. This includes keeping all of my appointments, cooperating with symptom review during Directly Observed Therapy, and submitting to blood, sputum and X-ray examinations.
- I agree to communicate with my nurse case manager, especially if I have any side effects or problems with TB medications.
- I agree to assist the TB Control Program to identify my contacts.
- I agree to follow the advice and instructions given by the TB Control Program and realize that there will be legal consequences if I fail to comply. I understand that state law allows the Tuberculosis Control Program to initiate involuntary detention when persons with TB fail to comply with treatment plans or isolation directives.
- I have had an opportunity to ask questions and have my questions answered.

 (Client's or Legal Guardian's Signature/relationship)

 Date

 (Public Health Designee's Signature)

 Date

 (Interpreter's Signature)

 Date

Copy given to the client

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