

## AGREEMENT FOR DIRECTLY OBSERVED THERAPY (DOT)

I, \_\_\_\_\_, am being treated for tuberculosis (TB).  
 I have been advised that:

- I must take TB medications for my health, and to stop spreading TB to others.
- Public Health provides Directly Observed Therapy (DOT) to persons with TB.
- An Outreach Worker will meet with me and observe me taking TB medications.
- I can get DOT at home, in the TB Clinic, or other locations the Outreach Worker and I agree on.
- I agree to Directly Observed Therapy (DOT) on the following schedule:

	Monday	Tuesday	Wednesday	Thursday	Friday
<b>Meeting Time*</b>					
<b>Location</b>					

\*within a two-hour timeframe (e.g., between 9 a.m. and 11 a.m.)

- I agree that if I can not meet for DOT at the agreed time, I will call my Outreach Worker or Nurse Case Manager the day before to make other arrangements.
- I agree to follow the advice and instructions given by the TB Control Program and realize that there may be legal consequences if I fail to comply.
- I have had an opportunity to ask questions and to have my questions answered.

<b>Client's or Legal Guardian's Signature:</b>	<b>Date:</b>
<b>Public Health Designee's Signature:</b>	<b>Date:</b>
<b>Interpreter's Signature:</b>	<b>Date:</b>
Nurse Case Manager: _____ Ph _____	
Outreach Worker: _____ Ph _____	

Copy given to the client

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

 <p style="text-align: center;"><b>COUNSELING FOR DOT</b></p> <p>Tuberculosis Control Program          Public Health-Seattle &amp; King County          Harborview Medical Center          325 – 9<sup>th</sup> Avenue PO Box 359776          Seattle, WA 98104          PHONE: 206.744.4579          FAX: 206.744.4350</p>	Patient Name:  HR #:  D.O.B.:
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