Washington State Department of Health

DOH 343-100 March 2011

TB Program Videophones

Videophone Directly Observed Therapy (DOT) Consent Form

Serial number _____

I am aware that I have been diagnosed with tuberculosis (TB). I will need a long course of medication for cure. I will be receiving by treatment from (enter name of local health jurisdictation {LHJ}) _____. Direct observation of medication dosing is normally done in the patient's home or at the treating facility.

During my treatment, observation of dosing will be performed using a videophone. I understand that a videophone will be placed in my home. I agree to allow the TB nurse or health worker to watch me take my medicines over the videophone at a prearranged time either daily or twice weekly.

I understand that I may switch back to standard in-home observed therapy at any time during the study. The use of videophone technology may have certain benefits to me. It is hoped that videophone Directly Observed Therapy will be less intrusive and allow greater flexibility in time of therapy. The use of videophone technology is not believed to carry any risk for the patient.

I understand that the videophone and attached phone cord and cables are the property of the Washington State Department of Health Tuberculosis Program. I agree to return all videophone equipment to (name of LHJ) _____ within four business days of the end of therapy. LHJ phone number_____

_____ _____

Signature of Patient (Parent/Guardian) Date

_____ _____

Signature of LHJ Nurse/Health Worker Date

Specific Procedure:

1. Turn on unit
2. Light must be shining at face
3. Display face and confirm with Health Department personnel your identity
4. Display pills
5. Swallow pills