Patient Electronic Directly Observed Therapy (eDOT) Agreement Form

Date: / /

Patient Name:

Provider Name:

I, , understand that I have been diagnosed with tuberculosis (TB) and have been prescribed medication by a physician to treat this disease. If my disease goes untreated, there may be serious consequences:

* My illness may last longer or become more severe.
* I may spread TB to others.
* I may develop and spread drug-resistant TB.
* I may die from TB.

During my treatment, observation will be performed remotely using electronic directly observed therapy (eDOT). This may be done using a smartphone or computer. I understand that the equipment provided to me (if any) is property of the Health Department. I agree to return all the equipment to the Health Department at the end of my treatment or upon request. I agree to allow the Health Department staff to watch me take my medicines via eDOT at a prearranged time.

To complete my treatment and protect my family and friends, I will:

* 1. Provide sputum specimens when requested.
	2. Keep all appointments for medical evaluation and x-rays.

eDOT Day(s): Time:

I understand that I may switch back to standard in-person DOT at any time during my treatment. I have read this agreement and understand the following (initial each box):

❏ My adherence to this treatment regimen is very important.

❏ I am responsible for the two tasks mentioned above.

❏ If I fail to complete these tasks, legal action may be taken to make sure I complete treatment.

Patient Signature: Date: / /

Health Department

Representative Signature: Date: / /