Directly Observed Therapy (DOT) Agreement

This DOT Agreement is designed to help everyone [patient, direct case manager, and Community Health Worker (CHW)] understand what is expected of them during DOT. The purpose is to promote communication and to lay out the roles and responsibilities for success. The agreement is signed at the beginning of DOT and can be changed as needed. All information will be kept confidential.

I understand that I will receive DOT as part of my TB treatment plan. The DOT plan has been explained to me. I understand that taking TB medicines is the most effective way to kill TB germs. I agree to have a health worker – local public health nurse or community health worker (CHW) – watch me take TB medicine according to the plan ordered by my doctor.

I, ____________________________________, understand and agree to the following:

1. I will be at:   __ Home    __Work    __Clinic/Local Public Health   __Other location (specify) ______________ at _______________  to receive my TB medicine.  
   (time)

2. If, for any reason, I cannot be present to take my medicine at the agreed upon place and time, I will call ______________________ at __________________ to change the appointment.  
   (DOT provider)                                     (telephone #)

3. I will tell my DOT provider of any complaints, questions, or problems that I have. I understand that if I am having side effects to the medicine, I may be asked to go to ______________________ to see a doctor.  
   (Name of clinic/hospital)

4. If I miss my DOT appointments and I do not take my medicine, my case manager/doctor may take stronger action to make sure I am taking my medicines.

_____________________________________   ______________________________
Patient signature     Date

I, ______________________________________________, agree to:

   (Primary DOT provider)

1. Observe patient taking TB medicines at the agreed place and time. If I need to change the appointment place or time, I will let the patient know in advance.
2. Keep patient information confidential.
3. Respond to questions or concerns patient may have.
4. Assist with referrals to other service agencies as appropriate.

________________________________________________________
Name and Signature of primary DOT provider          Date

________________________________________________________
Name and Signature of direct case manager           Date

Note to Local Public Health: Please fax signed agreement to DPH at 617-983-6990