Pou likit ak planteje nan oswa vini yo, rekre avèk konsanspad anpil la se "Direksyon Nan Jòd nan Desast Replika sèv ak lafitt Desast".
Directly Observed Therapy (DOT) Agreement

This form is designed to help patients and health workers understand what will happen during DOT. All information will be kept confidential.

I understand that I will get DOT as part of my tuberculosis treatment plan. The DOT plan has been explained to me. I understand that taking tuberculosis medicines is the most effective way to kill tuberculosis germs. I agree to have a health worker watch me take tuberculosis medicine according to the plan ordered by my doctor.

I, ___________________________, understand and agree to the following:

(Name)

1. I will be at: __ Home __ Work __ Clinic/Local Public Health __ Other location (specify) ____________ at ______________ to receive my tuberculosis medicine.

(time)

2. If I cannot take my medicine at that place and time, I will call ______________ at ______________ to change the appointment. (health worker)

(phone #)

3. I will tell my health worker 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 nurse/doctor may take stronger action to make sure I am taking my medicines.

______________________________
Patient signature

______________________________
Date

I, ___________________________, agree to:

(health worker)

1. Watch patient take tuberculosis 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 the patient’s questions or concerns.

4. Help with referrals to other service agencies if needed.

______________________________
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