

TB Program Videophones

Videophone DOT Consent Form

Serial number _____

I am aware I have been diagnosed with tuberculosis (TB) and will need to take medications for many months to be cured. I will be receiving treatment from (name of local health district) _____.

I was told that during my treatment, a health worker will watch me take my TB medications. Usually, this observation takes place either at the patient's home or in the clinic.

During my treatment, the health worker will watch me take my medications by videophone. I understand a videophone will be placed in my home. I agree to allow the health worker watch me take my medicines over the videophone at a prearranged time either daily or twice weekly.

I understand I may need to return to in-home observation of treatment at any time.

I understand the videophone and attached phone cord and cables are property of the Oregon State Department of Human Services Tuberculosis Program. I agree to return the videophone to (name/phone # of LHD) _____ within four business days after my treatment has ended.

Signature of Patient (Parent/Guardian)

Date

Signature of LHD Nurse/Health Worker

Date

Procedure:

1. Turn on unit
2. Light must be shining at face
3. Show face and confirm with health worker your identity
4. Show pills
5. Swallow pills