West Virginia Department of HEALTH

West Virginia Department of Health Tuberculosis Elimination Program – STATE FACILITY TREATMENT AGREEMEN

Patient Name: ____ Date: ____________________

I, _____________________________________, understand I have suspected or confirmed tuberculosis (TB) based on tuberculin skin test results, an abnormal chest film, laboratory findings and/or other diagnostic test results and have been prescribed a treatment regimen by a medical provider to treat this disease. If my disease goes untreated, there may be serious results such as:

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

While obtaining treatment at ____________________________________, a state-owned facility, I agree with the following measures:

- To take prescribed tuberculosis medications daily by direct observation therapy (DOT).
- To submit to necessary testing (sputa and blood specimens, chest x-rays) for evaluation as ordered by the physician.
- To remain at the above-mentioned institution until respiratory isolation is no longer required and a discharge plan has been approved by the WV Tuberculosis Elimination Program (WV TBEP), the hospital and the ____________________________ County Health Department may be implemented.
- To wear a mask in accordance with the above-named facility's policy.
- To refrain from drinking alcoholic beverages or using any drugs not ordered by the physician.

The staff of the ____________________________ County Health Department, WV TBEP and the above-mentioned institution are available to provide assistance/counseling to you concerning your tuberculosis disease and this treatment agreement.

By signing this treatment agreement, I acknowledge that I have read and agreed to the above conditions.

Patient: ____ Date: ___________________________

Witness: ____ **Date:** ___________________________

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https://oeps.wv.gov/tuberculosis/Pages/default.aspx