October 2024

West Virginia Department of HEALTH

West Virginia Department of Health – Tuberculosis Elimination Program
CONSENT TO PARTICIPATE IN LIVE VIDEO DIRECTLY OBSERVED THERAPY

Patient Name: _____ **Date of Birth**: ___ / ___ / ___

I know that I have been diagnosed with tuberculosis (TB) and the doctor has recommended that I start medication. The time frame I must take medication has been discussed with me by the doctor. It is the national standard of care that a health worker watch patients take each dose of their TB medications throughout their treatment. This is called directly observed therapy (DOT). DOT is normally done in the patient's home or at the local health department. During my treatment, my DOT will be done using live video.

I have talked about taking part in Video Directly Observed Therapy (VDOT) with the nurse from _____ County Health Department and agree to receive my treatment using live VDOT.

Please initial each box if you agree with each statement:

_____ I agree to allow the health department nurse watch me take my medicines using a live video application at an agreed upon time that is determined based on my treatment regimen.

_____ I know that I may choose to restart in-person DOT at any time during my treatment.

_____ I know that the health department nurse may require me to restart in-person DOT if I do not follow VDOT steps or if they feel in-person DOT would benefit me more than VDOT for any reason.

_____ I know that using VDOT may have certain benefits to me. It is hoped that VDOT will be less disruptive to me and give more flexibility with time and the location of treatment.

_____ I know that using VDOT is not believed to have any risk for me based on my eligibility.

_____ I know that the health department has tried to make VDOT secure, but cannot promise privacy of the broadcast images and I will not hold the local health department, the doctor or WV Tuberculosis Elimination Program responsible should my privacy be compromised.

_____ I will take my medications as ordered by the doctor. I will contact the health department immediately if I have any symptoms of a reaction to my TB medication. These symptoms have been discussed with me and a medication information sheet for each medication has been given to me.

_____ I will follow the steps listed below for each VDOT session:

1. Set a time for VDOT session.
2. Start the VDOT session with the health department nurse at the scheduled time.
3. Show my face and state my name.
4. Show each pill between my thumb and forefinger and then place the pill in my mouth.
5. Swallow pills and then show open mouth.
6. Share any questions or concerns I have with the health department nurse.

_____ ___ / ___ / ___
Signature of Client / Legal Representative Date

_____ ___ / ___ / ___
Signature of Health Department Nurse Date

_____
County of Patient's Residence