CONSENT FOR TREATMENT (Commonly Used Medications)

Name _____ Date _____

I consent to treatment for my tuberculosis exposure, latent TB exposure, and/or active TB disease with the following drugs: (Check box for drug client is on)

Medications	Things That May Happen:	Comments
☐ **Isoniazid** (INH)	Very tired; loss of appetite; dark urine; light colored bowel movement; yellow eyes and skin; tingling hands and feet; flushing; sweating or headache after a meal.	⚠ **Caution:** Avoid taking with food. Don't drink alcohol. Avoid using Tylenol (acetaminophen). No antacids within 2 hours.
☐ **Rifampin** (RIF) ☐ **Rifapentine** ☐ **Rifabutin**	Very tired; loss of appetite; dark urine; light colored bowel movement; yellow eyes and skin; flu-like symptoms; heartburn; bruising; vision changes (Rifabutin only). **Will turn body fluids orange (tears, urine, sweat).**	⚠ **Caution:** Avoid taking with food. Don't drink alcohol. **Birth control pills, shots, IUD, implant or ring may not work; use another method, such as condoms.** May discolor soft contact lenses.
☐ **Pyrazinamide** (PZA)	Very tired; loss of appetite; light colored bowel movement; yellow eyes and skin; joint aches; nausea; rash.	⚠ **Caution:** Don't drink alcohol. Avoid using Tylenol (acetaminophen).
☐ **Ethambutol** (EMB)	Difficulty seeing red and green colors, as they may look gray; vision changes; rash.	⚠ **Caution:** If you notice any vision changes, tell your healthcare provider immediately.
Fluoroquinolone: ☐ **Moxifloxacin** ☐ **Levofloxacin** ☐ **Ciprofloxacin**	Nausea and bloating; headache; dizziness; pain, swelling or tearing of the tendon; muscle or joint pain; heart palpitations.	⚠ **Caution:** Avoid taking within 2 hours of ingestion of milk-based products, antacids or vitamins. **Call healthcare provider immediately if you experience tendon, muscle, or joint pain.**

These possible side effects have been fully discussed with me by the physician and/or nurse. The benefits of this therapy have been explained to me, as well as the importance of taking the medication(s) regularly and consistently as recommended. I also understand that Directly Observed Therapy (DOT), where the nurse or an agreed upon responsible person watches me swallow my medication, is a nationally recognized standard of therapy.

I understand that most people can take the medication(s) without difficulty, but if I should develop any of the symptoms listed above, I am to contact _____ at _____ and ask to speak with a nurse. **I AM NOT TO WAIT UNTIL MY NEXT CLINIC APPOINTMENT,** but am to call right away for instructions for follow-up of my symptoms.

I have read this form or have had it explained to me. I have had an opportunity to ask my health care provider questions about my treatment and received a copy of my treatment plan. I understand the benefits and risks of taking these medications. I agree to take my Tuberculosis medications as directed.

_____ _____
Signature of person accepting treatment *(or parent or guardian)* Date

_____ _____
Printed Name Relationship to patient

_____ _____
Signature of Health Professional Witness Date

_____ _____
Health Professional Witness (print) Health Dept.

Adapted from Utah Department of Health