# CONSENT FOR TREATMENT (Seldom 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 |
|---|---|---|
| **INJECTABLES**<br>☐ **Capreomycin**<br>☐ **Amakacin**<br>☐ **Kanamycin**<br>☐ **Streptomycin** | Dizziness; ringing in the ears or hearing loss; irregular heartbeat; muscle weakness/cramps; trouble breathing; easy bleeding/bruising; decreased urination; balance problems; renal toxicity; rash. | ⚠ **Caution:** Soreness or hardening at the injection site. Do not drink alcohol. Drink plenty of fluids. Avoid pregnancy. |
| ☐ **Para-Aminosalicylate (PASER)** | Gastrointestinal distress; light colored stools; black stools or bleeding; dark brown urine; hypothyroidism; bleeding problems; loss of appetite; fatigue; yellow eyes or skin; rash | ⚠ **Caution:** Do not drink alcohol. Avoid using Tylenol (acetaminophen). Avoid pregnancy. |
| ☐ **Seromycin** (Cycloserine) | Nervous system side effects: seizures; tremor; headache; confusion; psychosis; suicidal ideation; hyper-irritability; aggression, trouble talking. Rash or hives. | ⚠ **Caution:** Don't drink alcohol. Avoid using Tylenol (acetaminophen). Avoid pregnancy. **If experiencing suicidal thoughts, increased depression or mental health changes, call your healthcare provider or 9-1-1 immediately.** |
| ☐ **Ethionamide** | Diarrhea; nausea; stomach; loss of appetite; fatigue; dark brown urine; light colored stool; yellow eyes or skin; hypothyroidism; metallic taste; depression; nervousness; easy bruising/bleeding; drowsiness; weakness; rash. | ⚠ **Caution:** Don't drink alcohol. Avoid using Tylenol (acetaminophen). Avoid pregnancy. **If experiencing suicidal thoughts, increased depression or mental health changes, call your healthcare provider or 9-1-1 immediately.** |

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*