



CONSENT AND TREATMENT PLAN FOR USE OF VIDEO DIRECTLY OBSERVED THERAPY (VDOT)

Table with 3 columns: Client Name, Address, Emergency Contact Person, DOB, City, Phone, Phone, Zip, Date.

I, _____ (Name of Client) have been advised and counseled by _____ (Name of Public Health Nurse), which based on available information, I qualify for use of the Video Directly Observed Therapy technology (VDOT) of the Illinois Department of Public Health (IDPH) Tuberculosis Prevention and Control Program (TB Program). The following are true:

- 1. I have been provided with education regarding my TB diagnosis and my medication.
2. I have met the IDPH criteria for non-infectiousness for my current condition.
3. I do not meet the case definition for multi-drug resistant TB as defined by the Centers for Disease Control and Prevention (CDC).
4. I agree to continue to follow my treatment plan and to take my TB medication as ordered for the entire length of treatment.
5. The side effects of the medication I am taking have been explained to me.
6. I agree to tell the local health department of changes to my housing situation, travel, health, and other pertinent information that may affect my treatment.
7. I am confident with my proficiency in using the VDOT program and know to contact my local health department if there are issues with the use of the technology.
8. If applicable, I will take care of the smartphone/tablet that is in my possession to ensure that both devices continue to function accordingly for the VDOT technology.
9. I will not tamper or try to change the settings of any smartphone/tablet that may be loaned to me for VDOT and would not conduct activities using the smartphone/tablet that are not pre-authorized by the local health department.
10. I will surrender any smartphone/tablet that may have been loaned to me if I am no longer enrolled in the VDOT program.

Client Signature: _____ Date: _____
Public Health Nurse/LHD: _____ Date: _____
Witness/Interpreter's Signature: _____ Date: _____