TB DISEASE DIRECTLY OBESERVED THERAPY (DOT) CLIENT AGREEMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DISEASE CONTROL AND FORENSIC PATHOLOGY
SFN 62203 (6-2023)

Name	Date of Birth
Child (whom I have Legal Custody)	

I, the above-named, or my child am/is being treated for tuberculosis disease.

Treated By

I have been informed that I/My child must take the prescribed anti-tuberculosis medications for the prescribed length of time as well as comply with other tests/treatments, such as x-ray or sputum exams.

During this treatment, observation will be performed utilizing Directly Observed Therapy (DOT). This can be done in-person or electronically. Electronic Directly Observed Therapy (eDOT) can be performed remotely using electronic media such as a smartphone applications or computer programs such as Skype, FaceTime, Facebook Messenger, Google Duo/Meet, Tango, WhatsApp, text message etc. (Video DOT). **This form of communication via Video DOT may not be secure or HIPAA-compliant and may pose a risk to one's privacy and health information.**

I agree to receive my treatment using Video DOT and allow _____ staff to watch me or my child take anti-tuberculosis medication via live video or pre-recorded video sent to the staff's phone by text or via computer at a pre-arranged time. I understand the risks associated with Video DOT.

In order to comply with Directly Observed Therapy I will:

- Schedule and Start Video DOT session at the scheduled time (for live video) or store and send recording via text or forward using the video application (for pre-recorded video).
- Use a live video application or video record myself self-administering or dispensing to my child anti-tuberculosis medication as prescribed at the planned time daily or multiple times a week.
- Start recording stating my name (first and last), my child's name as applicable, date (day, month and year), time (AM or PM), show my face, show pills to the camera, swallow the pills, and open my mouth to show the pills were swallowed, end recording, and send/forward recording to the staff.
- Report any adverse effects such as new rashes, itching, headaches, jaundice (yellowing of skin or eyes), nausea, vomiting or other concerning symptoms.
- Acknowledge that Video DOT will be less disruptive and gives me more flexibility with time and location of treatment. The dose does not count if I do not send the recording, and I will need to make it up later. If at any time I do not feel comfortable with Video DOT, I know I have the option of in-person DOT.

I agree to these special instructions as part of my treatment contract. I understand that refusal to comply with this voluntary contract or refusal to follow Video DOT steps will require me/my child to restart in-person DOT. Measures may be taken to ensure compliance, such as involuntary confinement by the health officer and court order according to NDCC 23-07.6 for failing to comply with DOT (eDOT or in-person DOT) requirements If I am determined to be a danger to others.

Name of Individual/Legal Guardian	
Signature of Individual/Legal Guardian	Date