



Alaska Division of Public Health

Prevention Promotion Protection

Consent to Participate in Live Video Directly Observed Therapy

Client Name: _____ Date of Birth: ___ / ___ / ___

Public Health Center Name: _____

Public Health Nurse Name: _____ Phone #: _____

I know that I have been diagnosed with (tuberculosis disease (TB) / latent tuberculosis infection (LTBI)) and that I need medication for treatment. I recognize it is the national standard that a health worker watches 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 Public Health Center. During my treatment, this observation will be done using (FaceTime / Skype).

I have talked about taking part in Video Directly Observed Therapy (VDOT) with my Public Health Nurse (PHN)/trained staff and I agree to receive my treatment with live VDOT using (FaceTime / Skype).

- I agree to allow PHN/trained staff watch me take my medicines using FaceTime or Skype at the planned time.
- I understand that I may choose to restart in-person DOT at any time during my treatment.
- I understand that my PHN/trained staff may require me to restart in-person DOT if I do not follow VDOT steps or if there are other circumstances that require to stop VDOT.
- I understand that using VDOT may have certain benefits to me, including flexibility with time and location of treatment.
- I understand that, at this time, there are no known medical risks involved with receiving my care in this way.
- I understand that the PHN/trained staff have made an effort to make VDOT secure, but cannot guarantee privacy of the broadcast.
- I will take my medications as ordered by my medical provider. I will contact my Medical Provider/Public Health Center immediately if I have any new rashes, itching, headaches, jaundice (skin or eyes turning yellow), nausea, vomiting or other concerning symptoms.
- In the event of technical failure of VDOT, I will call my Public Health Center to determine a plan to complete DOT.
- My PHN/trained staff has reviewed the procedure for completion of VDOT via live video with me and I have been provided with the opportunity to ask questions.
- If I have questions about my VDOT, I understand that I can call my PHN/trained staff.

- In the event of emergency, I agree to seek urgent medical care through the village clinic, the local Emergency Department or by calling 911.
- In the event I am unable to continue VDOT, I understand that my PHN/trained staff will coordinate in-person DOT.
- I will follow the steps listed below for each VDOT session:
 1. Set a time for VDOT session.
 2. Start VDOT session with PHN/trained staff at the scheduled time.
 3. Show my face and state my name.
 4. Show the pill bottle or pouch from which the pill is removed.
 5. Show the pill(s) between my thumb and forefinger and then place pill(s) in my mouth.
 6. Swallow pill(s) with at least 4 ounces of fluid.
 7. Show open mouth.
 8. Share any questions or concerns I have with the PHN/trained staff.

Signature of Client / Legal Representative

___ / ___ / ___
Date

Signature of PHN/trained staff

___ / ___ / ___
Date