

	Division of Community and Public Health	
	Section: 7.0 Court Force Handbook	Reviewed May 2020
	Subsection: 7.02.1 TB Patient Notification	Page 1 of 1

Tuberculosis (TB) Patient Responsibilities Notification

I, _____ (patient's name), understand I have been diagnosed with tuberculosis and that I have the following responsibilities in regards to my condition and treatment.

- That while infectious I must remain at home (including not working or attending school) so I will not spread TB bacteria to other people.
- If I must leave my home or I have guests into my home, I must wear the protective mask provided to me.
- That I will be placed on several different medications for the next several months and that this medication must be taken exactly as the doctor or nurse has instructed me to take it.
- That while on these medications I will be participating in Directly Observed Therapy (DOT) and must be available to the health care worker at the time and place we agreed upon to receive my medications.
- That while taking these medications I will report any serious side effects to my doctor or nurse. These side effects may include, but are not limited to, the following:

No appetite

Nausea

Vomiting

Yellowish skin or eyes

Fever for 3 or more days

Abdominal pain

Tingling fingers or toes

Skin rash

Tingling or numbness around the mouth

Easy bruising

Blurred vision

Ringing in the ears

Hearing loss

Dizziness

Aching joints

Easy bleeding

- That I must keep all scheduled appointments.

I understand that my failure to comply with these responsibilities could result in prolonging my illness and pose a health risk to others as long as I remain infectious. By my signature below I certify that my responsibilities in regards to my treatment for tuberculosis and the consequences of not meeting my responsibilities have been explained to me and that I understand these responsibilities. I further certify that my failure to meet these responsibilities could result in my involuntary hospitalization pursuant to § 199.180 of the Missouri Revised Statutes.

(Signature of Patient)

(Date Signed)

(Witnessed By)

(Date Signed)

I was present when the above was read to _____

(Witnessed by)

(Date Signed)