## Appendix A-eDOT Patient Agreement and Consent Form

_____ _____

Patient's full name Patient's Date of Birth

☐ I understand I have been diagnosed with tuberculosis (TB) and I have agreed to a treatment plan. I have been given the opportunity to ask questions about my diagnosis and treatment plan and all have been answered to my satisfaction. I understand that if I do not finish my treatment plan, there may be serious outcomes:

- My illness may last longer, become more severe, or become more difficult to treat and treatment may last longer.
- I may spread TB to others.
- I may die from TB.

☐ To complete my treatment and protect my family and friends, I will:

- Keep all appointments for medical evaluation and x-rays.
- Complete my eDOT appointments at the agreed upon time.
- Keep my monthly in-person appointment with the LPHA staff for monthly assessment. Notify my case manager as soon as possible if I am unable to keep an appointment and reschedule.

☐ I am aware that the current standard of care for TB disease is for treatment to be observed, called directly observed therapy (DOT). During DOT sessions, doses are observed in person.

☐ I agree that during my future treatment, electronic directly observed therapy (eDOT) will be performed via a recorded video using my personal smartphone. I have been trained how to use the eDOT application (app) and am able to use it comfortably. (*Initials of staff confirming proficiency)*_____

☐ I understand that I am responsible for paying for data and text messaging fees that occur as a result of my eDOT sessions. I also understand that I am responsible for ensuring that there are 300 MB of free space to allow video recording and upload for my eDOT sessions.

☐ I agree to allow the health department worker to watch me take my medicines as if I am at the health department office. I will upload the video by 8:00 AM the following day. Failure to comply with these terms will cancel this eDOT Agreement.

☐ I understand I must be completely clothed as if I was attending a clinic visit during my eDOT sessions. I must also be in an area appropriate for a meeting/home consultation while recording my eDOT session. There must be good lighting so that my face, hands, and pills can be seen at all times on my eDOT session videos and the area will be free from noise. Failure to comply with these terms will cancel this eDOT Agreement.

☐ I understand I may switch back to standard, in-person DOT at any time I choose or as recommended.

☐ I understand that I MUST report any side effects immediately to my case manager and stop treatment until I'm told it's OK to resume taking them. A list of possible side effects to watch for has been provided to me.

☐ I agree not to bring any financial or personal liability claim against the health department or any of their contractors, agents, officials, or employees, connected with the Missouri TB Elimination Program or my local public health agency, for any damages, expenses, or personal harm as a result of the use of eDOT.

Patient Signature: _____/_____ Patient Trainer: _____/_____
Date Date