

STATE OF MARYLAND TUBERCULOSIS PATIENT/PROVIDER AGREEMENT

Patient Name _____ DOB _____ Record # _____

- I know that I have suspected or confirmed tuberculosis (TB).
- TB can be spread to other people by coughing, speaking, or singing.
- TB treatment involves taking several drugs for a long time.
- My physician must report my TB disease to the health department.
- The health department's job is to see that my TB disease is treated.
- I know that the health department can take legal action if I do not follow my doctor's advice about my TB treatment.

Patient Responsibilities

I am responsible for:

- setting up regular appointment with the clinic to obtain my TB medicine.
- taking my TB medicine, each day, as I have been told to take it.
- calling the clinic if I have problems with my TB medicine.
- telling my doctor or nurse complete and truthful information when asked about past or current illnesses or medicines I am taking
- keeping my appointment for my TB treatment.
- telling the clinic as soon as possible if I cannot keep an appointment and then setting up a new appointment
- telling the clinic about anyone who may have been exposed to my TB.
- cooperating with tests (sputum, chest x-ray, etc.) related to my TB treatment.
- letting the clinic know of any changes in my address or phone number.

Provider Responsibilities

I am responsible for:

- clearly explaining TB disease and its risk to you and others you come in contact with, including your family.
- answering questions about your TB care and medicines.
- providing all medical care related to your TB.
- telling you about any changes in your health (lab test, x-rays, etc.).
- making sure that you get your TB medicine at a time we agree to.

Treatment Agreement

- I have read or had this agreement read to me, have had my questions answered, and have a copy to keep.
- I know that medicine has been given to me to cure my TB.
- I also know that because TB can be spread to other people, it is best for my health and the health of others that I take my TB medicine.
- I agree to follow the doctor's orders for TB treatment and take my TB medicine.

Patient or Parent/Guardian Signature DATE Provider Signature DATE