

West Virginia Department of Health and Human Resources – Division of TB Elimination
STATE FACILITY TREATMENT AGREEMENT

Patient Name: _____ Date: _____

I, _____, understand I have suspected or confirmed tuberculosis based on tuberculin skin test results, an abnormal chest film, laboratory findings and/or other diagnostic test results and have been prescribed treatment regimen by a medical provider to treat this disease. If my disease goes untreated, there may be serious results such as:

- My illness may last longer or become more severe
- I may spread TB to others
- I may develop and spread drug-resistant TB
- I can die from TB

While obtaining treatment at _____, a state-owned facility, I agree to the following measures:

- Take the prescribed tuberculosis medications daily by direct observation
- Submit to necessary testing (sputa and blood specimens, chest x-rays) for evaluation as ordered by the physician
- Remain at the above mentioned institution until respiratory isolation is no longer required and a discharge plan has been approved by the WV Division of TB Elimination, the hospital and the _____ County Health Department may be implemented
- Wear a mask in accordance with the above-named facility's policy
- Refrain from drinking alcoholic beverages or using any drugs not ordered by the physician

The staff of the _____ County Health Department, WV Division of TB Elimination and the above-mentioned institution is available to provide assistance/counseling to you concerning your tuberculosis disease and this treatment agreement.

By signing this treatment agreement I acknowledge that I have read and agreed to the above conditions.

Patient: _____ Date: _____

Witness: _____ Date: _____

Bureau for Public Health
Office of Epidemiology and Prevention Services
Division of Tuberculosis Elimination
Room 125, 350 Capitol Street
Charleston, West Virginia 25301-3715
(304) 558-3669 or 1-800-330-8126