LTBI Treatment Education and Statement of Consent in DOPT
_______________County/City Public Health Bureau

Name of Subject： _______________ **Identification Number：** ___________

Gender： _______________ **Date of birth：** ___________

Dear Sir/Madam:

The result of the latent tuberculosis infection (LTBI) test (Tuberculin Skin Test, TST or interferon-gamma release assay, IGRA), and the evaluation by the physician indicated that you have LTBI, but not active tuberculosis (TB). A complete course of treatment for LTBI can give more than 90% protection from developing active TB disease. This helps to effectively reduce the possibility of onset of TB disease and further transmission to the others.

Special Notice of LTBI treatment:

I. The following regimens are recommended for the treatment of LTBI.(Please mark V)

☐3HP：Three months of once-weekly isoniazid plus rifapentine (12 doses)

☐3HR：Three months of daily isoniazid plus rifampin (90 doses)

☐4R：Four months of daily rifampin (120 doses)

☐9H：Nine months of daily isoniazid (270 doses)

others：☐1HP：One month of daily isoniazid plus rifapentine (28 doses) or

☐preventive treatment of multidrug-resistant tuberculosis (MDR-TB).

Remark: ____________________

II. A directly observed preventive therapy (DOPT) observer will be arranged to provide DOPT service to help you complete the treatment.

III. You should have clinical evaluation at least once a month during the course of treatment. During the treatment, if you do not feel well (such as fever, dizziness, nausea, loss of appetite, pain in the upper right abdomen, numbness of limbs, yellowish skin or eyes, rashes, acute allergy, and other symptoms). Please inform the public health workers, or the TB case managers or the physicians in hospitals at once for management of the adverse events.

IV. If you have any questions, please do not hesitate to contact us at phone number_______________.

I hereby authorize the public health station under the ___________ County/City Public Health Bureau to safeguard my medications on LTBI, and the delivery of the medications by the public health workers for DOPT service.

LTBI Treatment and DOPT Consent

With regard to the declaration above:	**Relation between the undersigned and the subject of treatment**
☐Agree	**☐Myself ___________(signature)**
☐Disagree	**☐Appointed Guardian__________(signature)**

Date: ____________________