The information in this consent form is given so you can know more about your treatment. After you are sure that you understand this information sign this form to show that you do understand and agree to take the treatment.

I have been told I need drug treatment because of: **CIRCLE ONE**

 1. Tuberculosis exposure, no evidence of infection.

 2. Latent tuberculosis infection, no disease.

The following drugs have been prescribed: **CIRCLE ALL THAT APPLY**

1. Isoniazid (INH) 3. Rifapentine (RPT) 5. Levofloxacin (LFX)

2. Rifampin (RIF) 4. Rifabutin (RBT) 6. Moxifloxacin (MFX)

 7. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Some people who take these drugs may have one or more of the problems shown below:**

|  |  |
| --- | --- |
| **Isoniazid** | Decreased appetite, nausea, vomiting, abdominal discomfort/bloating, dark urine (tea or coffee color), yellow skin/eyes, rash, pale colored stools, tiredness, tingling of fingers or toes, vision changes (rare but possible: pain to eye, vision loss, loss of color vision, flashing lights, red/green color blindness). **Caution**: Avoid drinking alcohol. Limit use of acetaminophen products (i.e. Tylenol). May cause serotonin syndrome; avoid foods containing tyramine to include but not limited to: aged cheeses, processed meats, fermented foods, and chocolate. |
| **Rifampin** | Orange body fluids (tears, urine, sweat). May stain soft contact lenses or clothing. Flu-like symptoms, joint pain, tiredness, weakness, nausea, vomiting, stomach pain or cramps, heartburn, loss of appetite, yellow skin and/or eyes, itching, rash, bleeding from nose or gums or around your teeth, dizziness, musculoskeletal pain, fever or chills, light colored stools (poop), brown urine, bruises, or red or purple spots on your skin that you cannot explain, shortness of breath. **Caution:** Avoid drinking alcohol. May reduce the effectiveness of birth control pills and other hormonal contraceptives. If birth control is desired, an alternative method of birth control should be considered. Interacts with many other drugs. |
| **Rifapentine** | Same as Rifampin. **Caution**: Same as Rifampin.**Additional caution:** Rifapentine should not be taken during pregnancy. |
| **Rifabutin** | Same as Rifapentine and Rifampin. Also, vision changes (eye pain, vision loss, flashing lights, red/green color blindness), sore throat, sores in mouth. **Caution**: Same as with Rifampin. |
| **Levofloxacin** | Decreased appetite, nausea, vomiting, abdominal discomfort/bloating, tiredness, fainting, fever, rash, increased gas, headache, sleep problems, agitation, depression, tingling of fingers or toes, achiness, joint pain or swelling, pain in tendons usually at ankle, change in heart rate, photosensitivity, seizures. **Caution:** Do not take with milk-based products, antacids, multi-vitamins, mineral supplements (iron or magnesium) within 2 hours of medication; avoid caffeinated foods and beverages. Use sunscreen. |
| **Moxifloxacin** | Same as with Levofloxacin. **Caution**: Same as with Levofloxacin. |

**Allergic reactions including rashes and hives may be caused by any of the drugs. If severe immune reactions occur (including swelling of lips, breathing difficulty or wheezing), stop taking the drug and contact the nurse or physician immediately; or, to seek emergency medical help, dial 911 or visit the ER (Emergency Room) at a hospital.**

***For female patients:***

*I have been informed that I should not become pregnant while taking Rifapentine. I agree to use an effective birth control method while I am taking this medicine. If I am on birth control pills or taking another hormonal contraceptive, or using a hormonal contraceptive device, I will add a barrier method of contraception, such as a condom and spermicide while I am taking this medicine. I will inform the nurse or physician if I think I am pregnant.*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The risks are small and the health problems that may arise usually clear up completely. Sometimes the side effects may be bad, and very rarely they may cause lasting damage or death. My healthcare provider will check me regularly for side effects. **I will be responsible for telling my healthcare provider about any unusual symptoms and following treatment recommendations and instructions.** The Texas Department of State Health Services believes that the benefits of drug treatment for latent TB infection are usually much greater than the risks.

I have answered all of the questions about my medical history and my present health condition fully and truthfully. I have told the doctor or other clinic staff about any conditions that might suggest I should not take the medication(s). I have had the chance to ask questions about this health condition, the benefits and risks of specific tuberculosis drugs, including how long side effects may last and how bad the side effects may be. I understand the risks of not taking treatment. I understand that no promises can be made about prevention of disease or side effects. Any blank spaces on this form have been filled in.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Based on all the above and on what I have been told of the benefits as well as the risks of taking medicine for latent TB infection,

(**CIRCLE ONE**) **I consent** **I do not consent**

to the treatment for latent TB infection or tuberculosis exposure as recommended.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECTION I:**

Patient's name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient's Signature: Date:

Person authorized to consent (if not patient):

Relationship:

Signature: Date:

**SECTION II:** I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.

Patient's name:

Name of person giving consent:

Signature: Date:

Relationship to patient: Phone:

Address:

**SECTION III:**

Counselor's Signature: Date:

Interpreter’s Signature (If used): Date: