Texas Department of State Health Services

Patient Acknowledgment of Conditions for TB Isolation Release

Patient's Name: _____ Date of Birth: _____

Conditions for release from TB isolation and restrictions:

Based on information available at this time, you (probably/definitely) have TUBERCULOSIS (TB), which is a serious communicable disease. For you to be treated successfully, to decrease the possibility others will become sick, and to remain out of isolation, you must do the following: (Please initial each item).

_____ Keep all appointments with clinical staff as instructed.
_____ Follow all medical instructions from your physician or clinic staff regarding treatment of your TB.
_____Come to the Public Health Department Clinic or be at an agreed location and time for taking Directly Observed Therapy (DOT) or for video DOT (vDOT).
_____Do not return to work or school until authorized by your clinic.

Considerations/precautions after release from TB isolation and restrictions:

At this time, you have taken enough medication that you likely will not pass the disease to others, but you may still need to be cautious in certain settings. Even though you are released from TB isolation and restrictions and are free to move around the community for normal activities, please understand you may need to follow these instructions until further notice (health department will check if applicable):

- ☐ Avoid prolonged, close contact with very young children (less than 5 years old), the elderly, and/or anyone that you know or think is ill that we have not already identified and discussed. If you must be around these types of people, you must wear a surgical mask unless otherwise instructed by the health department.
- ☐ Wear a surgical mask when in a hospital, medical, or any clinical environment.
- ☐ Not applicable.

Return to work/school after release from TB isolation and restrictions:

You currently work/attend school at _____ in the position of a/an _____and it has been determined you may/may not return to work at this time. *If you are unable to return to work now, we will continue to assess your potential return on a weekly basis.*

Signature/Acknowledgement:

Your signature below means that you have fully read and understand this document. You also acknowledge that your isolation release status may be revoked if you do not adhere to the directions of your health department physician/clinic.

Patient/Guardian Signature: _____ Date: _____

Witness/Nurse: _____ Date: _____