IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

PATIENT TREATMENT WAIVER

Patient Name:	DOB:	Phone:
Address:	City:	Zip:

I have been told about Tuberculosis (TB) disease.

I understand why I should:

- ☐ Be evaluated for TB
- ☐ Take medicine for TB
- ☐ Other _____

I have decided that I do not wish to follow the medical recommendations offered.

- I have been told that the signs and symptoms of active TB disease are fever, night sweats, cough lasting more than 3 weeks, coughing up blood, chest pain, fatigue, and unexplained weight loss.
- I understand that if I develop any signs and symptoms of active TB disease, I need to seek medical care right away.
- I understand that TB is an infectious disease that can be passed to others and that legal steps can be taken if I do not seek medical care and consequently put others at risk of getting sick or infected.

I, therefore, take personal responsibility regarding the possible future development of tuberculosis that may have been prevented if I had followed the above recommendations.

Client Signature: _____ Date: _____/_____/_____

Public Health Nurse: _____ Date: _____/_____/_____

Witness/Interpreter's Signature: _____ Date: _____/_____/_____