

HOME ISOLATION AGREEMENT

Date: _____

Patient Name: _____

DOB: _____

Street Address: _____

Phone: _____

City/State _____

ZIP: _____

The above named patient has a communicable disease in a communicable stage and has been placed in isolation by their physician and/or the County Health Officer. Therefore, the following conditions must be followed:

The Patient agrees to:

1. Remain isolated to his/her private residence (or the address above) until determined to be non-infectious.
2. Not have contact with persons who do not reside at the above residence; therefore, visitors will be not be allowed in the residence until the isolation has been rescinded.
3. Allow TB Control Staff to monitor compliance with home isolation including unscheduled visits and phone calls.
4. Go to medically necessary medical appointments AND agrees to wear a mask when going to medical appointments until isolation has been rescinded
5. _____

Non-infectious status will be determined by subsequent sputum smears, compliance with TB treatment, and clinical response to treatment. Isolation will be rescinded by the County Health Department as soon as the patient is determined to be non-infectious and on adequate Directly Observed Therapy for tuberculosis.

I understand that if I fail to comply with these conditions, further legal action may be taken, possibly resulting in court ordered detainment. I have read the above information and understand it.

Patient's Signature

Date

Interpreter's Signature (if needed)

Date

PHN or Designee Signature

Date

Copy given to patient _____ (PHN or designee initials)

SAMPLE: to use with all infectious TB patients
Print on letterhead

HOME ISOLATION AGREEMENT

Date: _____

Patient Name: _____ DOB: _____

Street Address: _____ Phone: _____

City: _____, OR ZIP: _____

The above named patient is reasonably suspected of having a communicable disease in a communicable stage and has been placed in isolation by his/her physician and/or the Pubic Health Administrator or Health Officer for the County. Oregon Revised Statute 433.010 Spreading disease prohibited states, "No person shall willfully cause the spread of any communicable disease within this state." Therefore, the following conditions must be followed:

1. The patient agrees to remain isolated to his/her private residence (or the address above) until determined to be non-infectious.
2. The patient agrees to not have contact with persons who do not reside at the above residence; therefore, visitors will be not be allowed in the residence until the isolation has been rescinded.
3. The patient agrees to allow TB Control Staff to monitor compliance with home isolation including, unscheduled visits and phone calls.
4. The patient may go to medically necessary medical appointments AND agrees to wear a mask when going to medical appointments until isolation has been rescinded.
5. Other:

Non-infectious status will be determined by subsequent sputum smears, compliance with TB treatment, and clinical response to treatment. Isolation will be rescinded by the County TB Program as soon as the patient is determined to be non-infectious and on adequate Directly Observed Therapy for tuberculosis.

I understand that if I fail to comply with these conditions, further legal action may be taken, possibly resulting in court ordered detainment. I have read the above information and understand it.

Patient's Signature Date

Interpreter's Signature (if needed) Date

Tuberculosis Control Staff Person Signature Date
(Revised Jan/04)

Instructions for Patients with Infectious Tuberculosis (TB)

Prepared by the Communicable Disease Control Program (208) 327-8625

People with infectious TB can spread the infection to others until medications have made the person noncontagious (not able to spread TB germs). This usually takes between 2 weeks and 2 months. It is very important to prevent others from getting infected. Until a public health worker from Central District Health Department tells you that you are no longer contagious, please follow these instructions carefully.

- **Stay isolated at your residence.**
 - You should stay at your residence except for doctor's appointments. If you have a necessary doctor's appointment with a doctor who does not know you have TB, you should inform the office staff ahead of time.
 - You should not be inside your residence or a car or a building with anyone who is not a member of your immediate household.
 - If you have to go to a doctor's appointment, you must wear a mask outside your home, when you're in a car with others and when you are inside the medical clinic.

- **Visitors should not come inside your home.**
 - In an emergency if a visitor must come inside your home, wear a mask when you answer the door. Warn the visitor that without wearing a mask, he or she is in danger of accidentally becoming infected with TB. Immediately give the visitor a mask when they enter your home. Both you and your visitors must wear masks the entire time they are there. Make the visit as brief as possible. Only in extreme emergencies should children under 5 years visit your home.
 - You may visit with people outdoors without wearing a mask. Stay at least one arm length away from others.

- **Do not go to work, religious services, school or other places.**

- **Cover your nose and mouth with disposable tissues when coughing.**

If necessary, the Central District Health Department will pursue legal action to attempt to make sure that people who are contagious with TB stay isolated until they are no longer contagious. Your signature below indicates you have received and understand these instructions.

Patient

Date

Central District Health Dept. Rep.



ISOLATION INSTRUCTIONS

Name: _____

DOB: _____

Date: _____

Your doctor has determined that you may be/are contagious for pulmonary Tuberculosis (TB). This means that you are able to spread the disease through coughing, sneezing, singing or shouting. TB is spread when people share the same air in a room or house with a contagious person. TB cannot be spread by sharing food, hugs or kisses, clothing, eating utensils or bathroom facilities.

You need to stay at home until the doctor notifies you that you are no longer contagious. This time period is different for each person. Do not go into buildings where there are people, including stores, church, school or work. This isolation does not prohibit you from obtaining legal or medical services.

If you have no other alternative, you may go inside a building, **but you must wear a properly fitted mask.** The mask you wore at Infections Ltd. for your appointment is sufficient. When you enter a facility, you must notify them that you have contagious tuberculosis. If there are questions, call the Tacoma-Pierce County Health Department at 253 798-6410, then press "0". Wearing a mask at home is not necessary, because anyone who was in your household before you were diagnosed has already been exposed.

During the isolation period, no one should enter your home except those persons who live in the residence. The bacteria remain in the air and can infect persons even if you are not in the house.

The TB germ is killed by sunlight and is diluted by having fresh air move through the room. Please try to keep curtains, shades or blinds open to let sunlight in. During warm months, please open windows to allow in fresh air. Use tissues to cover your mouth and nose when coughing or sneezing.

We realize that this isolation may be difficult for you, however, it is important to safeguard the public's health, and this is the responsibility of the Health Department. Tuberculosis is a disease that is easily prevented if precautions are taken, and it can be cured.

If you have any questions, call Dr. Lawrence Schwartz, Dr. Marina Arbuck or the Health Department.

I have read and understand the above instructions and information. I agree to follow these instructions until notified by my doctor that I am no longer contagious.

Patient or Representative Signature

Date

Health Department Representative

Date

Translator

Date

Tacoma-Pierce County Health Department
3629 South D Street
Tacoma, WA 98418
253-798-6410

INSTRUCCIONES PARA UN AISLAMIENTO
(INCOMUNICACION – CUARENTENA)

NOMBRE: _____ FECHA DE CUMPLEANOS: _____
FECHA: _____

Su Doctor ha determinado que usted (ustedes) puede (pueden) tener Tuberculosis Pulmonar (TB) contagiosa. Esto significa que usted (ustedes) tienen la posibilidad de propagar esta enfermedad a través de un catarro, un estornudo, cantando o gritando. TB se puede propagar cuando la gente comparte el mismo aire en un cuarto o de una casa con alguien que este contagiado (o sea que tenga tuberculosis). TB no se propaga compartiendo comida, abrazos o besos, ropa, utensilios para comer (cucharas, tenedores, cuchillos) o facilidades sanitarias (indoors, banns, lavatories).

Usted necesita quedarse en su casa hasta que el doctor le notifique que usted ya no esta contagiado (o sea ya no es propagador de esta enfermedad). El periodo de tiempo para la cur es different con cada persona. No vaya a edificios en donde hay gente, esto incluye tiendas, iglesias, escuelas o lugares de trabajo. El estar aislado (o sea durante el tiempo de aislamiento) no le prohíbe a usted obtener servicios legales o medicos.

Si usted no tiene otra alternativa, usted puede entrar a un edificio pero debe usar una mascara que este propiamente ajustada. La mascara que usted usa para sus citas en Infecciones Ltd. es suficiente. Cuando usted entre en una facilidad (edificio) les debe de notificar de que usted tiene una tuberculosis contagiosa. Si tiene preguntas, llame al Departamento de Salud del Condado de Tacoma-Pierce al telefono 253 – 798 6410, despues marque el “0”. No es necesario que use la mascara en su casa porque cualquier persona que viviera en ella antes de ser usted diagnosticado, ya estuvo expuesta al contagio.

Durante este periodo de aislamiento, nadie debe de visitar o entrar en su casa excepto aquellos que viven en la residencia. La bacteria permanece en el aire y puede contaminar a cualquier persona que entre aunque usted no este en la casa.

El germen de TB se puede matar con la luz del sol y es diluido (destruido) haciendo correr aire fresco a través del cuarto. Por favor trate de mantener las cortinas o persianas abiertas para dejar entrar la luz del sol. Durante los meses calientes, por favor abra las ventanas para que permita la entrada de aire fresco. Use pañuelos de papel para cubrirese la boca y nariz cuando tosa o estornude.

Nosotros nos damos cuenta de que este aislamiento es difícil para usted, sin embargo, es importante proteger la salud publica y esta es la responsabilidad del Departamento de Salud. La tuberculosis es una enfermedad que es facil de prevenir si se toman precauciones y se puede curar.

Si usted tiene alguna pregunta, llame al doctor de Infecciones LTD (428-8700, o al Departamento de Salud.

He leído y entiendo las instrucciones e información arriba mencionada. Estoy de acuerdo en seguir estas Instrucciones hasta que el médico me notifique de que ya no estoy contagiado (por lo tanto no hay peligro de que contagie a nadie).

Firma

Fecha

Departamento Del Salud

Fecha

Translator

Fecha

VOLUNTARY ISOLATION/QUARANTINE AGREEMENT

I, _____, date of birth _____, gender _____
(full name - please print legibly)

M__ F__, have agreed to be [] isolated
[] quarantined

at:

(premises subject to isolation and quarantine)

pursuant to WAC 246-100-040 et seq. I understand that my isolation or quarantine

commences on (moment of signing) _____ and _____,
(date) (time)

and will remain in effect for _____ days, unless rescinded by the health officer.

I acknowledge that my rights have been explained to me, and that I understand the reasons that isolation or quarantine is necessary, namely:

Suspected Communicable Disease or Infectious Agent if Known: Tuberculosis

Medical Basis on Which Decision to Isolate or Quarantine Is Justified:

[] You are suspected of having been exposed to _____ and are potentially currently infectious to others.

[] You have been diagnosed with an active case of _____ and you are in all likelihood currently infectious to others.

[] Other: _____

Special Instructions:

It is very important for the protection of your own health and that of others that you abide by this Voluntary Isolation/Quarantine Agreement. If you have any questions about this Agreement or need assistance in complying, please call:

The Health Officer may seek your voluntary compliance, may mandate isolation or quarantine, or may petition the Superior Court for an order authorizing isolation or quarantine or continued isolation or quarantine for a period up to 30 days.

**Local Health Officer or His Designee
Tacoma-Pierce County Health Department.**

IMPORTANT NOTICE

You have the right to petition the Superior Court for release from isolation or quarantine in accordance with WAC 246-100-055. You have the right to legal counsel. If you are unable to afford legal counsel, then counsel will be appointed for you at government expense and you should request the appointment of counsel at this time. If you currently have legal counsel, then you have an opportunity to contact that counsel for assistance. If you require a translator, one will be provided for you, and a copy of all relevant documents will be sent to you in an interpreted form. A complete copy of your rights shall be attached to this form.

I, _____, acknowledge that I have received a copy of the Voluntary Isolation/Quarantine Agreement, and that I have read or had read to me said Order and that I understand and agree to the terms therein. I further agree that I am voluntarily entering isolation or quarantine.

Signed _____ . Dated this _____ day of _____, 20____.

Internal use only:

Dated this _____ day of _____, 20____.

Date copies of Written Order was delivered to person or group of persons: _____ . Method of delivery: personal service _____; registered mail _____ . If the order relates to a group and the order is posted, date and location of posting: _____ .

Aislamiento Voluntario/ Acuerdo sobre Cuarentena

I, _____, fecha de nacimiento _____
(Nombre completo, legible)

Genero M__ F__ Yo estoy de acuerdo en aislamiento cuarentena

en: _____
(el lugar sujeto a aislamiento ó cuarentena)

conforme con la ley WAC 246-100-040 et seq. Yo entiendo que mi aislamiento ó cuarentena comienza en (el momento en que firme).

_____ y _____,
(fecha) (hora)

y se mantendrá en efecto por _____ days, recindible solamente por el Oficial del Departamento de Salud.

Mis derechos han sidos explicados y yo entiendo las razones por las que tengo que ser aislado ó puesto en cuarentena , nombrar la razón:

Agente Infeccioso ó Enfermedad Comunicable: **Tuberculosis**

Decisión médica por la que se ha decidido aislar ó poner a este paciente en cuarentena:

Se sospecha que Ud ha sido expuesto a _____ y puede infectar a otros.

Ud ha sido diagnosticado con un caso activo de _____ y existe la posibilidad que infecte a otros.

Otro: _____

Intrucciones Especiales:

Es importante para la protección de su salud y la de otros que Ud cumpla con el acuerdo de aislamiento ó cuarentena. Si Ud tiene alguna pregunta sobre este acuerdo ó necesita ayuda llame a:

El oficial del Departamento de Salud puede pedir su acuerdo voluntario, demandar su aislamiento ó pedir una orden de aislamiento ó cuarentena por un periodo de 30 days a la Corte Superior.

**Oficial de Salud Local ó persona designada.
Departamento de Salud del Condado Pierce**

Noticia Importante

Ud tiene el derecho de pedir ser liberado de su cuarentena a la Corte Superior de acuerdo a la ley WAC 246-100-055. Ud tiene derecho a consejeria legal. Si Ud no puede pagar por un consejero legal, un consejero sera designado a Ud a costo del gobierno y Ud debe pedirlo en este momento. Si Ud tiene un consejero, entonces Ud tiene una oportunidad de contactarlo ahora y pedir asistencia. Si Ud require un traductor, dejenos saber. Copias de todos estos documentos seran proveidos en su idioma. Un acta completa de sus derechos estará adjunta.

Yo, _____, admito que he recibido una copia del acuerdo de mi cuarentena ó aislamiento voluntario y entiendo los terminos incluidos. Yo entiendo y estoy de acuerdo en comenzar mi aislamiento ó cuarentena voluntariamente.

Firma _____ . Fecha _____, 20____.

Para uso oficial:

Fecha _____ dia _____, 20____.

Las Ordenes Escritas fueron enviadas a la persona ó grupo de personas:

_____. Metodo de envio: _____; servicio personal: _____; correo registrado _____ . Si la orden se relaciona a un grupo y la orden esta al tanto, fecha y lugar: _____.

**ORDERS TO VOLUNTARILY COMPLY
WITH TUBERCULOSIS CONTROL MEASURES
(sample2004)**

PURSUANT TO THE AUTHORITY IN OREGON STATUTE, SECTION 433.006, 433.010, AND OREGON ADMINISTRATIVE RULES 333-019-000, THE PUBLIC HEALTH ADMINISTRATOR or HEALTH OFFICER OF _____ COUNTY HEREBY REQUESTS THE FOLLOWING:

ORDER ISSUED BY: _____ DATE: _____

Signature: _____ Title: _____ of _____ County

Orders Shall Remain In Effect Until Rescinded By _____.

ORDERS ISSUED TO:

Name of person: _____
Address: _____
_____, OR _____
Telephone No: (_____) _____ - _____
Date of Birth: _____
Social Security No. _____ - _____ - _____

It appears to the Administrator/Health Officer that you have active TB or there are reasonable grounds to believe that you have active TB;
YOU ARE HEREBY ORDERED TO COMPLY WITH THE FOLLOWING TUBERCULOSIS CONTROL MEASURES:

GENERAL CONTROL MEASURE	SPECIFICS
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<input checked="" type="checkbox"/> Isolation to place of residence or other location ORS 433.006 and ORS 433.010 OAR 333-019-0000	You are hereby ordered isolated at the following location on the following terms and conditions: LOCATION: Address _____ _____, Oregon
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Date Rescinded: ___/___/___

CONDITIONS:

1. You must remain in isolation at the above location until you are deemed non-infectious (cleared) by the _____ County Health Department.
2. Until you are on adequate treatment for TB and are cleared by _____ County Health Department, you may only leave your place of isolation to go to medical appointments or the hospital, with the condition that you wear your TB mask. You must return directly to your place of isolation upon discharge from the medical appointment or hospital.
3. No visitors, including visitors to other household residents, will be allowed to enter this location during the period of isolation.
4. Only the residents currently residing at this location may continue to reside there. No new residency can be allowed until you are on adequate treatment for TB and are cleared by _____ County Health Department.

- Required medication and Directly Observed Therapy
ORS 433.006 and ORS 433.010
OAR 333-019-0000

Date Rescinded: ___/___/___

You are hereby ordered to complete the following appropriate prescribed course of medication:

1. TB medications must be taken once daily.
2. All the TB drugs will be dispensed and observed once daily as follows for the Initial Phase of treatment:
Isoniazid (INH) _____mg
Rifampin (RIF) _____mg
Pyrazinamide (PZA) _____mg
Ethambutol (EMB) _____mg
3. The Continuation Phase: The physician will adjust the medication regimen when culture and susceptibility results are known and after all the doses from the initial phase have been taken.

LOCATION: _____

DAYS: Monday-Tuesday-Wednesday-Thursday-Friday
(on Friday, a package of TB medicine for Saturday and a package for Sunday will be left for you to take on the appropriate day)

TIME: at _____ am / pm

CONDITIONS:

1. _____ County Public Health Staff will dispense your medication and observe you ingesting your medication at the above location, on the days specified above, at the time specified.
2. This schedule may be changed upon mutual agreement of you and _____ County Public Health Staff:
 - a.
 - b.
 - c.Phone number: (_____) _____-_____.
3. This schedule may also change to ingesting medication two times a week, upon recommendation of the physician, and when you can tolerate the increased doses.

- Exclusion from workplace or other place.
ORS 433.006 and ORS 433.010
OAR 333-019-0000

Date Rescinded: ___/___/___

You are hereby ordered excluded from the following locations on the following terms and conditions:

Work:

School:

Other: Any public building or place (except for medical appointments as discussed in the isolation section).

Once you are on adequate treatment and are not infectious, the _____ County Health Department will rescind this order.

- Additional orders
ORS 433.006 and ORS 433.010
OAR 333-019-0000

Date Rescinded: ___/___/___

1. Follow all TB control measures.
2. Appear at all appointments given you by your treating physician and by _____ County Health Department.
3. Comply with your treating physician's requests for testing necessary to monitor your response to treatment and to monitor for side effects.

INDIVIDUALIZED ASSESSMENT OF YOUR CIRCUMSTANCES

The individualized assessment of your circumstances or behavior constituting the basis for the Administrator/Health Officer to issue this order is as follows:

List ALL details of your reasons for issuing orders: e.g./

1. *You were prescribed TB medications that you did not take (dates of missed doses)*
2. *You currently are refusing to take your TB medication.*
3. *You are currently refusing : (medical exams (sputums, blood lab work, etc)*
4. *You were diagnosed with active TB in _____ and eloped from care before completing treatment.*
5. *Per your physician's report you have been non-compliant with other medical treatment recommendations:*
 - a.)
 - b.)
 - c.) *etc.*
6. *Unstable lifestyle: no permanent housing (living with friends, family, or at a shelter), unemployed, psychiatric diagnosis not well controlled, etc.*

1. The following less restrictive treatment alternatives were attempted in your and were unsuccessful:

(Samples: if none, state so & give reasons for giving orders initially - e.g./ past history of non-compliances) (if past TB treatment history, list:)

- a. *Voluntary self-ingestion of TB medications (dates) with documented non-compliance (e.g./ pill counts off, pharmacy check = patient did not refill TB meds, etc.)*
- b. *Voluntary attendance at medical appointments (PMD reported patient missed the following appointments:)*

2. The reasons less restrictive treatment alternatives were considered and rejected in your are as follows:

A. Attempt at self-administration again. Rejected because:

- 1) TB is treatable and curable IF medications are taken as directed. If untreated, 25% of cases die within 2 years, 50% die within 5 years, 25% remain alive infecting others in the community.
- 2) Drug resistance can develop quickly if patients do not take their medication correctly.
- 3) If drug resistance develops, the chance for a successful cure decreases and could result in your death
- 4) Cases with a history of non-compliance with treatment usually continue with non-compliant behavior if treatment is not directly observed. *(add to statement, if appropriate: You have demonstrated non-compliant behavior in the past as discussed above.)*

B. Isolation at home without TB treatment. Rejected because: *(list reasons- see samples below)*

- 1) *The patient does not live alone, and with untreated TB, could infect other residents of the household.*
- 2) *There are young children in the home. Young children infected with TB can rapidly develop fatal forms of TB.*
- 3) *The patient is currently medically fragile as evidenced by _____, and needs assistance with daily living so cannot live alone.*

You are also ordered to submit to a photograph for purposes of identification. (*optional - if photos are possible*)

Failure to comply with this order may subject you to further legal action, including jail.

**Signature of person
serving notice:** _____ **Date:** _____

**Signature of
patient:** _____ **Date:** _____
(if case refuses, the person serving the notice should write that in on the patient signature line)

**Signature of
interpreter:** _____ **Date:** _____
(if needed)