

Direct Observed Therapy Agreement
Pregnancy and HIV
Pediatric AIDS Chicago Prevention Initiative (PACPI)

Date _____
Name _____
DOB _____
Address _____
City _____ ZIP _____
Phone _____ 2nd Phone _____

I understand that one of the most effective ways to reduce my baby's chance of getting HIV infection during the pregnancy and delivery is to take HIV medications twice per day at the same times each day.

I understand that one of the most effective ways to take HIV medications regularly is to participate in a Direct Observed Therapy (DOT) program. My doctors have prescribed a Direct Observed Therapy program which is to start immediately.

I understand that frequent blood draws will be a necessary part of a home-based Direct Observed Therapy program. I will cooperate with weekly blood draws and clinic visits if my doctors think it is necessary.

I understand that if my blood results show that the home-based Direct Observed Therapy program is effective, the program will continue until the baby is born.

I understand that if my blood results show that the home-based Direct Observed Therapy program is not effective, medications may be changed, I may have to be hospitalized for several days or weeks before the baby's birth, and/or doctors may recommend caesarian section.

I, _____ understand and agree to the following:
Name of Client

1. For my morning medications, I will be at _____ between the hours of _____ and _____ to take my medications.
2. If I am unable to be present as above, I will call _____ at _____ to _____ phone _____ make another plan. I will call at least _____ ahead of scheduled time.

3. For my evening medications, I will be at _____ between the hours of _____ and _____ to take my medications.

4. If I am unable to be present as above, I will call _____ at _____ to _____ phone _____ make another plan. I will call at least _____ ahead of scheduled time.

5. I understand that the DOT observer's job is to see and document that I take my medicines as prescribed on time and to notify the health care team if there are problems. I will cooperate with this.

6. I understand that the DOT Observer will maintain confidentiality. The DOT Observer is not to share information about me except with the health care team.

7. If I have any complaints or problems about the home-based Direct Observed Therapy program, I will contact _____ at _____ name _____ phone _____.

Name of client

DOT Program Manager

Physician

Anne Statton, PACPI Project
Director
312-334-0974