

TO: Riverside University Health System
Public Health – TB Control
P.O. Box 7600 Riverside, CA 92513-7600
Phone: (951) 358-5107 Fax: (951) 358-7922
After Hours: 1 (888) 430-5195

**Confidential
TB Discharge Plan and
Approval Form**

From (Facility Name):
Telephone:
Return Fax#:

Name: (Last, First, MI): AKA: Age / DOB: Soc. Sec. #: Sex:
 Male Female

Head of Household Relationship Language: Bilingual: Race: Married:
 Yes No Yes No

Current Address (P.O. Box, General Delivery, Star Route – give location directions): Occupation: Phone Number:

Person to Notify in Case of Emergency & Phone#: Insurance Plan: Plan Number: Employer / Phone#: DOC# / Booking#:

Physical Description (Height, Weight, Hair Color & Style, Scars, Tattoos, etc.): Hospital M.R.#: PO's Name/Phone#

CLINICAL INFORMATION – TO BE COMPLETED BY PHYSICIAN

MAJOR SITE: Pulmonary Other _____

RISKS: (Check all that apply)
Immunocompromised* ETOH Abuse IVDU
 Yes No Yes No Yes No
*Reason: _____

SKIN TESTS / INTERFERON GAMMA RELEASE ASSAY (IGRA)
PPD Date: _____ Result: _____ mm. Not Done
Boost PPD Date: _____ Result: _____ mm. Not Done
IGRA result: Positive Negative Not Done
Controls: Yes No Reactive: Yes No
Antigen: Candida Mumps Tetanus Tricophyton

BACTERIOLOGY

Source: _____ Smear #1 Date: _____ Time: _____ <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Unk <input type="checkbox"/> Not Done Culture #1 <input type="checkbox"/> Pos <input type="checkbox"/> Mtb <input type="checkbox"/> NonTB <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Not Done <input type="checkbox"/> Unk	Source: _____ Smear #2 Date: _____ Time: _____ <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Unk <input type="checkbox"/> Not Done Culture #2 <input type="checkbox"/> Pos <input type="checkbox"/> Mtb <input type="checkbox"/> NonTB <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Not Done <input type="checkbox"/> Unk	Source: _____ Smear #3 Date: _____ Time: _____ <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Unk <input type="checkbox"/> Not Done Culture #3 <input type="checkbox"/> Pos <input type="checkbox"/> Mtb <input type="checkbox"/> NonTB <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Not Done <input type="checkbox"/> Unk
---	---	---

GeneXpert: Pos MTB Neg Pend Unk Not Done
 PCR: Pos MTB Neg Pend Unk Not Done

TB TREATMENT Not Ordered

NURSE OBSERVED INGESTION OF MEDS: Yes No
FREQUENCY: Daily Bi-Weekly Other: _____

Drug	Dose	Date Started	# Given	Adverse Reaction
INH				
RIF				
PZA				
EMB				

Sensitive to all drugs: No Please Specify: _____
 Yes Pending Unknown See Attached

Allergies: _____
 Other Medications: _____

Comments: _____
 CM/IP: _____ Phone# _____

DISCHARGE PLANS

TB Follow-up: Health Dept. RUHS-MC Other: _____

PMD Name: _____
 Address: _____ Ph#: _____
 Follow-up Appointment Date: _____
Discharge To: Shelter Home SNF Jail/Prison Other Facility Name: _____
 Address: _____
 Phone#: _____
Anticipated Discharge Date: _____
 If followed by Health Department, is a reply requested? Yes No

CONTACT INFORMATION & HOUSEHOLD COMPOSITION

Testing to be done by: Health Dept. RCRM PMD Other: _____
 # of Children: _____ Children ≤ 4 yrs: Yes No
 # of Adults: _____ Immunocompromised Persons: Yes No

HEALTH DEPARTMENT OFFICIAL USE ONLY: DISCHARGE APPROVED: Yes No

Problems Identified:	Action Required:

Date

Secondary LHD Signature/Title

Date

Riverside County Signature/Title