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: ❒ Yes ❒ No	Race:	Married: ❒ 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* ❒ Yes ❒ No
ETOH Abuse ❒ Yes ❒ No
IVDU ❒ 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: ___________	**Source**: ___________	**Source**: ___________
Smear #1	**Smear #2**	**Smear #3**
Date: _____________	Date: _____________	Date: _____________
Time:_____________	Time:_____________	Time:_____________
❒Pos❒Neg ❒ Pend	❒Pos❒Neg ❒ Pend	❒Pos❒Neg ❒ Pend
❒Unk ❒ Not Done	❒Unk ❒ Not Done	❒Unk ❒ Not Done
Culture #1	**Culture #2**	**Culture #3**
❒ Pos ❒ Mtb ❒NonTB	❒ Pos ❒ Mtb ❒NonTB	❒ Pos ❒ Mtb ❒NonTB
❒ Neg ❒Pend	❒ Neg ❒Pend	❒ Neg ❒Pend
❒ Not Done ❒ Unk	❒ Not Done ❒ Unk	❒ Not Done ❒ Unk

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

CHEST X-RAY (Please fax a copy of the CXR/CT report)

Follow-up chest x-ray: ❒ Improving ❒ Stable ❒ Worsening ❒ Unknown
Date: ________________

CLINICAL ASSESSMENT

Signs/Symptoms: ____
Reason Hospitalized:________________________Date:__________
Patient requires chemotherapy / radiation? ❒ Yes ❒ No
Patient on dialysis? ❒Yes ❒No Is patient diabetic ❒Yes ❒ No
VNA/HHA care required? ❒Yes ❒No Is pt on insulin ❒Yes ❒ No

Physician's Name: ______________________________________
Physician's Signature: ___________________________________
Phone#: ( ) _____________________ Date: ______________

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. ❒ RCRMC ❒ 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.❒RCRMC❒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:**

Secondary LHD Signature/Title | Date

Riverside County Signature/Title | Date