

TO: County of Riverside, Community Health Agency Department of Public Health – TB Control P.O. Box 7600 Riverside, CA 92513-7600 Phone: (951) 358-5107 Fax# (951) 358-7922		<h1 style="margin: 0;">Confidential</h1> <h2 style="margin: 0;">TB Discharge Plan and Approval Form</h2>		From (Facility Name): Telephone: Return Fax#:	
Name: (Last, First, MI):		AKA:	Age / DOB:	Soc. Sec. #:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Head of Household	Relationship	Language:	Bilingual: <input type="checkbox"/> Yes <input type="checkbox"/> No	Race:	Married: <input type="checkbox"/> Yes <input type="checkbox"/> 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:	PO's Name / Phone#:	DOC# / Booking#:
Physical Description (Height, Weight, Hair Color & Style, Scars, Tattoos, etc.):				Hospital M.R.#:	

CLINICAL INFORMATION – TO BE COMPLETED BY PHYSICIAN

MAJOR SITE: <input type="checkbox"/> Pulmonary <input type="checkbox"/> Other _____ RISKS: (Check all that apply) Immunocompromised* <input type="checkbox"/> Yes <input type="checkbox"/> No ETOH Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No IVDU <input type="checkbox"/> Yes <input type="checkbox"/> No *Reason: _____			SKIN TESTS / INTERFERON GAMMA RELEASE ASSAY (IGRA) PPD Date: _____ Result: _____ mm. <input type="checkbox"/> Not Done Boost PPD Date: _____ Result: _____ mm. <input type="checkbox"/> Not Done IGRA result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done Controls: <input type="checkbox"/> Yes <input type="checkbox"/> No Reactive: <input type="checkbox"/> Yes <input type="checkbox"/> No Antigen: <input type="checkbox"/> Candida <input type="checkbox"/> Mumps <input type="checkbox"/> Tetanus <input type="checkbox"/> Tricophyton		
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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
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CHEST X-RAY (Please fax a copy of the chest x-ray report)

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

CLINICAL ASSESSMENT

 Signs/Symptoms: _____
 Reason Hospitalized: _____ Date: _____
 Patient requires chemotherapy / radiation? Yes No
 Patient on dialysis? Yes No
 In-home care required? Yes No
 Physician's Name: _____
 Physician's Signature: _____
 Phone#: () _____ Date: _____

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

TB CHEMOTHERAPY 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				

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

Allergies: _____
 Other Medications: _____
 Comments: _____

Case Manager/Contact Person: _____
 Telephone#: () _____

CONTACT INFORMATION & HOUSEHOLD COMPOSITION

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

HEALTH DEPARTMENT OFFICIAL USE ONLY: DISCHARGE APPROVED: Yes No

Problems Identified:	Action Required:

Riverside County Signature / Title:	Date:	Secondary LHD Signature / Title:	Date:
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