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

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:	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: ❒ 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

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

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: _____

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				

Allergies: _____
Other Medications: _____
Comments: _____

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

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:**