GOTCH TUBERCULOSIS DISCHARGE PLAN

Clear Form | Print

To: TB Control Officer Nevada County Public Health Phone: (530) 265-1420 Fax: (530) 271-0836	☐ **INITIAL REPORT** ☐ **READMISSION** ☐ **TRANSFER** ☐ **DISCHARGE**	From:

PATIENT INFORMATION			Race/Ethnicity/Language:
Name (last, first, middle):			AKA:
Address Prior to Admission:	Age:	DOB:	Occupation:
Address After Discharge/Transfer:			Phone:
Legal Guardian/Next of Kin:			Phone:
Parole Officer:		Phone:	Booking #:
HOSPITALIZATION INFORMATION Name of Institution			Date of Admission:
Hospital Physician's Name and Phone #:			

Please fax the following: ☐ **Face sheet** ☐ **Insurance info.** ☐ **Imaging reports** ☐ **History & Physical** ☐ **Consult notes**
☐ **MARS** ☐ **Bacteriology/Pathology reports** ☐ **TST/QFT results** ☐ **Lab results: Chem/CBC** ☐ **Discharge Summary when available**

PATIENT TB INFORMATION

Status: ☐ Suspect ☐ Verified ☐ Immunosuppressed/HIV

Site: ☐ Pulmonary ☐ Laryngeal ☐ Extrapulmonary Site:

Date (mm/dd/yy)	AFB Source Site	AFB Smear Results	NAAT/ PCR Results	AFB Culture Results	Organism Identified

Medication	Dosage/Frequency	Date Started	Date Stopped	Initial Chest X-ray (CXR) Date:	Results: ☐ Cavitary ☐ Noncavitary ☐ Normal
INH				Most Recent Follow-up CXR Date:	Results: ☐ Improved ☐ Stable ☐ Worse ☐ Not Done
RIF				Most Recent TST/IGRA Date:	☐ Mantoux _____ (mm induration) ☐ IGRA ☐ Negative ☐ Positive
EMB				Weight (kg): Date:	Household: Number of Adults = Number of Children = ☐ Newborn/Child under 5 yrs ☐ Immunocompromised:_____
PZA				**DISCHARGE PLANNING** Anticipated Discharge Date:	
Other:				Discharge To: ☐ Home ☐ Shelter ☐ Jail/Prison ☐ Skilled Nursing Facility ☐ Homeless ☐ Other (specify):	

Primary Medical Provider: Phone:	Medical Provider for **Tuberculosis Treatment After Discharge**: Phone: Follow-up Appointment Date and Time: _____ @ _____ ◯ AM ◯ PM
Completed By:	Phone: Fax: Date:

Discharge Approved: ☐ **Yes** ☐ **No. If denied, see below for action required.**

HEALTH OFFICER/TB CONTROLLER RESPONSE

☐ Nevada County TB Control Approval

_____ _____
Signature & Date of discharge Approval by Health Officer/designee

☐ Secondary TB Control Approval

_____ _____
Signature & Date of discharge Approval by Health Officer/designee