COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
PUBLIC HEALTH DEPARTMENT

TUBERCULOSIS DISCHARGE TREATMENT PLAN

PART I: DISCHARGE INFORMATION (Provider to complete)

PATIENT NAME	DATE OF BIRTH	SEX ☐ M ☐ F	DISCHARGE FACILITY

Anticipated Discharge Date: ____ Discharge to: ☐ Home ☐ Skilled Nursing Facility ☐ Residential Facility ☐ Shelter ☐ Jail/Prison ☐ Other (Specify) ____

Discharge Location: STREET	CITY	ZIP CODE	PHONE NUMBER

Medical Provider for TB Care After Discharge	PROVIDER ADDRESS	PROVIDER PHONE NUMBER

TB Follow Up Appointment Date: ____ Time: ____ ☐ AM ☐ PM

INSURANCE PAYOR: ____

PART II: DISCHARGE MEDICATIONS/TREATMENT PLAN (Provider to complete)

CURRENT BACTERIOLOGY | **DISCHARGE MEDICATIONS** | **Weight:** ____ (kg)

DATE mm/dd/yy	TIME am/pm	SPECIMEN SOURCE	RESULTS SMEAR	RESULTS CULTURE	RESULTS NAAT	MEDICATION	DAILY DOSAGE (mg)	START DATE
						ISONIAZID		
						RIFAMPIN		
						PYRAZINAMIDE		
						ETHAMBUTOL		
						B6		
						Other: ____		
						Other: ____		
						Minimum of 7-day supply of TB medications to be given at discharge ☐ Yes ☐ No		

OTHER TESTS

☐ Chest X-ray Date: ____
☐ WNL ☐ Non-Cavitary ☐ Cavitary ☐ Miliary

☐ CT Scan Date: ____
☐ WNL ☐ Non-Cavitary ☐ Cavitary ☐ Miliary

TB Skin Test: Date Placed: ____ Date Read: ____ Results: ____ mm

Quantiferon: Date Drawn: ____ ☐ Neg ☐ Pos ☐ Indeterminate ☐ Pending

HIV Test Done: ☐ Yes ☐ No

DIAGNOSIS

☐ Active TB ☐ Suspect Active TB
☐ Pulmonary
☐ Extrapulmonary (site) ____
☐ Clinical Diagnosis (without lab confirmation)

COMPLETED BY	DATE	PHONE NUMBER	FAX NUMBER

PART III: HEALTH DEPARTMENT REVIEW (TB Control to complete)

Action(s) Required Prior to Discharge: ____

Discharge Approved: ☐ Yes ☐ No

____ Date: ____
(*Signature of TB Controller or Designee*)