

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* _____ ETOH Abuse _____ IVDU _____
 Yes No Yes No 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: _____ 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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GeneXpert: Pos MTB Neg Pend Unk Not Done
PCR: Pos MTB Neg Pend Unk Not Done

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# _____

CHEST X-RAY (Please fax a copy of the CXR/CT 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 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: _____

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:

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