San Mateo County Tuberculosis Control
Discharge Planning Summary

San Mateo County Health Department
225 W. 37th Avenue, San Mateo, CA 94403
(650) 573-2346 (650) 573-2919 (Fax)

Patient Information

Patient name- Last First MI AKA:			Date of Birth (mm/dd/yy) _____/_____/_____		Age	Gender ☐ Male ☐ Female
Address			Telephone number ( )		Other number (specify) ( )	
City		County	State	ZIP code	Social Security number _____/____/_____	
Race/ Ethnicity	Primary Language	Guardian/ Parent (If Minor)	Health Insurance		Occupation	
Country of Birth			Date Arrived in U.S. Month/Year:_____/_____			

Hospital Information

Name of Institution & Reporting Unit	Medical Record #	Admission Diagnosis		Date of Admission
Address		Telephone number ( )		Fax number ( )
City	County	State	ZIP code	
Medical Provider		Provider Phone #:		

Patient TB Information

TB Status Suspect ☐ Confirmed ☐	Date of Diagnosis _____/_____/_____	Symptom Onset Date _____/_____/_____	Site of TB Pulmonary ☐ Laryngeal ☐ Extra-pulmonary ☐ _____

Immunocompromised Yes ☐ No ☐	Homeless Yes ☐ No ☐	Hx of Substance abuse Yes ☐ No ☐ Specify: _____	Psychiatric Disability Yes ☐ No ☐	HIV Test Offered? Yes ☐ No ☐ Result: Pos ☐ Neg ☐

Bacteriology: (Include specimens collected during the current admission)

Date	Source	AFB Smear	AFB Culture	Organism Identified	Lab name

Chest X-Ray: Date: _____/_____/_____ Cavitary ☐ Non-Cavitary ☐ Normal ☐	Follow-up Chest X-Ray: Date: _____/_____/_____ Improved ☐ Stable ☐ Worse ☐ Not done ☐	Tuberculin Skin Test (TST): Yes ☐ ____mm No ☐ Date: ___/_____/_____	Quantiferon: Yes ☐ No ☐ Date: _____/_____/_____ Result: Pos ☐ Neg ☐ Indeterminate ☐

Discharge Planning Summary

Patient Name: _____ **DOB:** _____

TB Medication Regimen				
Date medication started: _____/_____/_____	Patient's Weight: _____lbs_____kg	Allergies:		
Isoniazid (INH) _____mg po qd	Rifampin (RIF) _____mg po qd	Ethambutol(EMB) _____mg po qd	Pyrazinamide (PZA) _____mg po qd	Vitamin B6 _____mg po qd
Streptomycin _____ mg IM qd	Other: _____mg___	_____mg_____	_____mg____	_____mg_____
Note: TB Medications should be given *once daily*.				
Is there a change of TB medication regimen upon Discharge? Yes ☐ No ☐ If yes, please provide medication name and dosage:				
Other Non-TB Medications taken regularly:				

Discharge Information		
Estimated date of Discharge (Pending Health Department Approval):_____/_____/_____	Discharge to: Home ☐ Shelter ☐ SNF ☐ Other ☐ _____	
Medical Provider after Discharge:	Provider Phone #:	Follow-up Appt Date: _____/_____/_____
Household Composition: ☐ Child < 5 years old ☐ Immunocompromised person	Number of Children: _____ Number of Adults: _____	
Anticipated adherence to TB medications after discharge : ☐ Good ☐ Fair ☐ Poor	Case reported to San Mateo County Health Department Yes ☐ No ☐ Date Reported: ____/____/____ If not, please do so by calling (650) 573-2346 fax: (650) 573-2919	

Provider Signature			
Provider Signature Title	Date	Phone number	

For Discharge Approval Fax Completed Form To TB Control
Fax: 650-573-2919 Main Line: 650-573-2346
After Hours (After 5:00 pm) or Weekend Call: 650-363-4981

Health Officer/ TB Controller Review	
Discharge Approved Yes ☐ No ☐	*If Discharge not approved see attached for action required.*
Signature of TB Controller/Health Officer:	**Date:**