



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	Date of Birth (mm/dd/yy) ____/____/____		Age
AKA:						
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 <input type="checkbox"/> Confirmed <input type="checkbox"/>	Date of Diagnosis ____/____/____		Symptom Onset Date ____/____/____		Site of TB Pulmonary <input type="checkbox"/> Laryngeal <input type="checkbox"/> Extra-pulmonary <input type="checkbox"/> _____	
Immunocompromised Yes <input type="checkbox"/> No <input type="checkbox"/>	Homeless Yes <input type="checkbox"/> No <input type="checkbox"/>		Hx of Substance abuse Yes <input type="checkbox"/> No <input type="checkbox"/> Specify: _____	Psychiatric Disability Yes <input type="checkbox"/> No <input type="checkbox"/>	HIV Test Offered? Yes <input type="checkbox"/> No <input type="checkbox"/> Result: Pos <input type="checkbox"/> Neg <input type="checkbox"/>	
Bacteriology: (Include specimens collected during the current admission)						
Date	Source	AFB Smear	AFB Culture	Organism Identified	Lab name	
Chest X-Ray: Date: ____/____/____ Cavitary <input type="checkbox"/> Non-Cavitary <input type="checkbox"/> Normal <input type="checkbox"/>		Follow-up Chest X-Ray: Date: ____/____/____ Improved <input type="checkbox"/> Stable <input type="checkbox"/> Worse <input type="checkbox"/> Not done <input type="checkbox"/>		Tuberculin Skin Test (TST): Yes <input type="checkbox"/> ____mm No <input type="checkbox"/> Date: ____/____/____		Quantiferon: Yes <input type="checkbox"/> No <input type="checkbox"/> Date: ____/____/____ Result: Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/>

Discharge Planning Summary

Patient Name: _____

DOB: _____

TB Medication Regimen				
Date medication started: _____/_____/_____		Patient's Weight: _____lbs _____kg		Allergies:
Isoniazid (INH) _____mg po once daily	Rifampin (RIF) _____mg po once daily	Ethambutol(EMB) _____mg po once daily	Pyrazinamide (PZA) _____mg po once daily	
Vitamin B6 _____mg po once daily	Streptomycin _____mg IM once daily	Other: _____mg_____	_____mg_____	_____mg_____
Note: TB Medications should be given <i>once daily</i>.				
Is there a change of TB medication regimen upon Discharge? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> Shelter <input type="checkbox"/> SNF <input type="checkbox"/> Other <input type="checkbox"/> _____
Medical Provider after Discharge:	Provider Phone #:	Follow-up Appt Date: ____/____/_____
Household Composition: <input type="checkbox"/> Child < 5 years old <input type="checkbox"/> Immunocompromised person		Number of Children: _____ Number of Adults: _____
Anticipated adherence to TB medications after discharge : <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Case reported to San Mateo County Health Department Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>	<i>If Discharge not approved see attached for action required.</i>
Signature of TB Controller/Health Officer:	Date: