Santa Barbara County PUBLIC Health DEPARTMENT

TUBERCULOSIS DISCHARGE TREATMENT PLAN

Forms that are incomplete may result in delayed approval

PART I: DISCHARGE INFORMATION (Facility to complete)

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

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

Discharge Location: STREET	CITY	ZIP CODE	PHONE #

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

LAB RESULTS/TESTS

Date Collected mm/dd/yy	Time Collected am/pm	Specimen Source	AFB Smear	AFB Culture	GeneXpert (PCR)	HIV	Quantiferon (IGRA)

OTHER TESTS

TB Skin Test: Date Placed: _____ Date Read: _____ Results: _____ mm ☐ Not Done	☐ Chest X-ray Date: _____ ☐ WNL ☐ Non-Cavitary ☐ Cavitary ☐ Miliary ☐ Not Done	☐ CT Scan Date: _____ ☐ WNL ☐ Non-Cavitary ☐ Cavitary ☐ Miliary ☐ Not Done

TB MEDICATIONS Weight: (kg)

MEDICATION	DAILY DOSAGE (mg)	START DATE
ISONIAZID		
RIFAMPIN		
PYRAZINAMIDE		
ETHAMBUTOL		
B6		
Other:		
Other:		

Minimum of 3-day supply of TB medications to be given at discharge
☐ Yes ☐ No

DIAGNOSIS

☐ Active TB ☐ Suspect Active TB

☐ Pulmonary

☐ Extrapulmonary (site) _____

If site of disease is extrapulmonary, pulmonary disease must be clinically ruled out

☐ Clinical Diagnosis (without lab confirmation)

COMPLETED BY:	DATE	PHONE #	FAX #

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*)