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 ☐

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 *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:**