# CONTRA COSTA HEALTH SERVICES

## Public Health Tuberculosis Control Program

**TB CASE REPORT: REQUEST FOR DISCHARGE**

**Phone: 925.313.6740 Fax: 925.313.6465**

**Hospital:**______________________________ **Phone:**(_____)______________________

**Contact Person:**______________________________ **Fax:**______________________

**Today's Date:**_____/_____/_____

**Name:**______________________________ **Alias:**______________________________
LAST FIRST MI LAST FIRST MI

**Home Address :**______________________________________________
STREET CITY ZIP CODE COUNTY

**Sex:**_______ **Age:**_______ **Date of Birth:**_____/_____/_____ **Phone number:**(_____)______________________

**Race/Ethnicity:**

☐ White, non-Hispanic ☐ Black, non-Hispanic ☐ Hispanic ☐ Native American/Alaskan Native

☐ Asian/Pacific Islander (specify)______________________ ☐ Other (specify)______________________

**Primary language if other than English:**______________________________

**Please fax the following:** ☐ ***Face sheet*** ☐ ***Insurance info.*** ☐ ***Imaging reports*** ☐ ***History and Physical*** ☐ ***Consult notes*** ☐ ***MARS*** ☐ ***Bacteriology/Pathology reports*** ☐ ***TST/QFT results*** ☐ ***Lab Results: Chem/CBC*** ☐ ***Dischg Summary when avail.***

**HIV Status** ☐ **Negative** ☐ **Positive** **If results are positive, provide copies of HIV results, CD4 count and Viral Load**

**TB DISCHARGE MEDICATION REGIMEN**

| Medication | Dosage | Start Date | Other TB Medications | Dosage | Start Date |
|---|---|---|---|---|---|
| Rifampin | | | | | |
| INH | | | | | |
| PZA | | | | | |
| Ethambutol | | | | | |
| B6 | | | | | |
| Weight/Kg: | Comments: | | | | |

**DISCHARGE PLANS**

| Date of discharge: | Discharge to:<br>☐ Home ☐ SNF | Discharge address if not home: |
|---|---|---|
| Household: # of adults: # of children: ages of children: # of immunocompromised: | | |
| Patient's verbal understanding of TB dx:<br>☐ Yes ☐ No | Rx or TB Meds.: ☐ Yes ☐ No<br># of days of meds. | Home isolation:<br>☐ Yes ☐ No |
| TB care provided by:<br>☐ Health Dept. ☐ Other | Treating MD Name:<br>Phone:<br>Appt. Date: | PMD Name:<br>Phone: |
| Final DX (if not TB): | | |

**PUBLIC HEALTH TUBERCULOSIS CONTROL PROGRAM REVIEW**

| Discharge approved:<br>☐ Yes ☐ No | Problems identified:<br>☐ Yes ☐ No | Action required prior to approval:<br>☐ Yes ☐ No |
|---|---|---|
| Comments: | | |

**Signed:**______________________ **Title:**______________________ **Date:**__________ **Time:**______________