



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 Imaging disk
 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: <input type="checkbox"/> Home <input type="checkbox"/> SNF	Discharge address if not home:
Household: # of adults:	# of children:	ages of children:
Patient's verbal understanding of TB dx: <input type="checkbox"/> Yes <input type="checkbox"/> No		# of immunocompromised:
TB care provided by: <input type="checkbox"/> Health Dept. <input type="checkbox"/> Other		Home isolation: <input type="checkbox"/> Yes <input type="checkbox"/> No
Treating MD Name: Phone: Appt. Date:		PMD Name: Phone:
Final DX (if not TB):		

PUBLIC HEALTH TUBERCULOSIS CONTROL PROGRAM REVIEW

Discharge approved: <input type="checkbox"/> Yes <input type="checkbox"/> No	Problems identified: <input type="checkbox"/> Yes <input type="checkbox"/> No	Action required prior to approval: <input type="checkbox"/> Yes <input type="checkbox"/> No
Comments:		

Signed: _____ Title: _____ Date: _____ Time: _____