County of Orange Health Care Agency/Pulmonary Disease Services
Telephone: (714) 834-8033 FAX: (714) 834-7956
Hospitalized TB Patient Transfer and Discharge Plan Approval Request

Patient Name: _____ **Submitted by:** _____ **Date:** ___/___/____
DOB: ___/____/_____ MRN: _____ **Facility:** _____
SSN: _____ Gender: M F **Phone:** _____ **Pager:** _____
Language Spoken: _____ **Fax:** _____
Parent or guardian: _____

Discharge to: [ ] Home [ ] SNF [ ] Residential Facility [ ] Other _____
Discharge address: _____ Phone # _____
Date of discharge: _____/_____/_____ F/U Appt: _____/_____/_____
Physician assuming TB Care: _____ Physician Specialty: _____
Physician's address: _____ Phone # _____

Diagnosis: [ ] Active TB [ ] TB Suspect [ ] Pulmonary TB [ ] Extra-Pulmonary TB (site) _____
Date of TST: _____/_____/____ Result: _____ mm [ ] TST not read [ ] TST not done [ ] Previous TST +
TB symptoms: [ ] cough [ ] hemoptysis [ ] fever [ ] weight loss [ ] fatigue [ ] night sweats
Chest X-ray result: _____
Pertinent Medical History: _____

AFB Smear Results

Date of collection	Specimen type:	AFB Smear Results:
_____/_____/_____	_____	_____
_____/_____/_____	_____	_____
_____/_____/_____	_____	_____

Treatment*:* (weight: _____ lbs/kg)

Medications		*Frequency*	*Date TB meds started*
INH	_____ mg	_____	_____/_____/_____
Rifampin	_____ mg	_____	_____/_____/_____
Ethambutol	_____ mg	_____	_____/_____/_____
Pyrazinamide	_____ mg	_____	_____/_____/_____
B6	_____ mg	_____	_____/_____/_____
Other	_____	_____	_____/_____/_____

Number of doses supplied at discharge: _____

Faxed prescription to TB Control
[ ] Yes [ ] No

All Orange County patients to be discharged on Directly Observed Therapy

Contact Information/Household Composition

Number of people in the household? _____
Are there children under 5 years of age? [ ] Yes [ ] No
Are there immunocompromised individuals? [ ] Yes [ ] No

For TB Control use only

Comments:_____
_____

Discharge approval: [ ] Yes [ ] No **Date of approval**: _____/_____/_____
Approved by: _____ **Phone** #: _____

To facilitate a timely and appropriate discharge, the provider should submit this form to Orange County TB Control 1 to 2 days prior to date of anticipated discharge. TB Control will review the discharge plan for approval or denial.