



MADERA COUNTY PUBLIC HEALTH DEPARTMENT

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PUBLIC HEALTH DIRECTOR

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TUBERCULOSIS DISCHARGE PLANNING SUMMARY

Patient:	Hospital/Corrections:
DOB:	Contact Person:
Medical Record #:	Phone:
	FAX:

DISCHARGE INFORMATION

Anticipated Discharge Date: / /	Medical Provider after Discharge:
Discharge to:	
Address:	Phone:
Phone:	Follow up appt: / /

DISCHARGE DRUG REGIMEN

Medication:	Dose:	Start Date:	Estimated Stop Date:	Number Provided:

Cough or Sputum Production Present:	Yes	No
Prior TB Drug Resistance:	Yes	No
Prior TB Drug Adherence:	Good	Poor Unknown Not Applicable
Anticipated adherence to TB med on disch:	Good	Poor Unknown Not Applicable
Is Directly Observed Therapy (DOT) Planned?	Yes	No
Where is DOT to occur?	Site:	
How often will DOT be administered?	Daily	2x/wk 3x/wk
Contact Investigation to be completed by:	Health Department	PMD
Household Composition:	Children under 1 yr of age: Total Children: Total Adults:	
	Household Member Immunocompromised: Y N	

Form Completed by: _____ Phone: _____

Health Dept to FAX reply to: _____ FAX: _____

HEALTH DEPARTMENT REVIEW

Discharge Approved: Yes No	
Problems Identified:	
Actions required prior to discharge:	
Approved by: _____	Date: / /