TB Treatment/Discharge Plan

2005A-TB-004

Patient Name	Gender ☐ M ☐ F	DOB	SSN
Address			Telephone
Occupation	Work Site		Work Phone
Emergency Contact	Address		Phone

TO BE COMPLETED BY THE TREATING PHYSICIAN OR FACILITY

Case reported to the local health department by: ______________________________ on (date) ____________

The TB care physician will be: ☐ LHD ☐ Private Physician ______________________________

Physician Address ______________________________ Phone ____________

Other follow-up caregivers: ______________________________
(name, agency, & phone)

Drugs and dosages prescribed Patient body weight _______ kg

☐ Isoniazid _____ mg ☐ Rifampin _____ mg ☐ Pyrazinamide _____ mg ☐ Ethambutol _____ mg

☐ B-6 ____ mg ☐ other ___________________ ☐ other __________________

To be ingested: ☐ daily ☐ 2x weekly ☐ 3x weekly

Adherence Assurance: ☐ DOT ☐ Physician Certification

All patients will be contacted by LHD for case management and contact investigation, if indicated. DOT is the standard of care for all TB cases. For any patient not on DOT, the treating physician accepts responsibility for assuring that the patient completes appropriate treatment and is required to provide the LHD with written certification of treatment adherence.

Infectious: ☐ Yes ☐ No ☐ Don't know

Identify any treatment adherence obstacles:

☐ homelessness ☐ physical disability ☐ substance abuse: ______________________________

☐ mental disability ☐ none ☐ other: ______________________________

Identify any personal service needs:

☐ housing assistance ☐ food/nutrition ☐ local/state welfare ☐ child care ☐ transportation

☐ drug treatment ☐ mental health services ☐ home health services ☐ employment services ☐ none

☐ other: ______________________________

Referrals for these needs were/will be made to: ______________________________ on (date) ____________

Other considerations/comments: ______________________________

TO BE COMPLETED BY THE LHD AND PROVIDED TO THE PHYSICIAN / FACILITY

The assigned Public Health Nurse Case Manager is: ______________________________ Phone: ____________

Initial DOT visit will be made by: ______________________________ (name)

1st DOT appointment: ____________ ____________ ____________
date time place

The DOT worker(s) will be: ______________________________ (name) ☐ health dept staff ☐ other ____________

DOT will be done at ______________________________ (address) ☐ home ☐ school ☐ work ☐ other
(Schedule to be established by DOT worker and patient at first visit. The patient will sign a DOT agreement that includes DOT instructions.)

Primary responsibility for contact investigation: ☐ case manager ☐ other ______________________________

Proposed interventions for identified obstacles to adherence: ______________________________

Other considerations/comments: ______________________________

____

The following individuals have been notified and approve of the above treatment plan.

Signatures and approval must be obtained prior to patient discharge.

Attending physician signature______________________________ date ____________

Local Health Department signature______________________________ date ____________

Patient signature ______________________________ date ____________

☐ Patient elected not to sign: Discharge planner signature______________________________ date ____________