CORRECTIONAL FACILITY
TUBERCULOSIS PATIENT PLAN

[ ] Initial Report Date _____
[ ] Transfer Date _____
[ ] Discharge Date _____

Patient/Inmate Name _____ DOB _____ AKA _____ Sex [ ] M [ ] F
MR# / ID# / CDC# _____
Facility Patient is Leaving: _____ Admission Date: _____ Discharge/Transfer Date: _____
Planned Discharge/Transfer to [ ] Home [ ] Shelter [ ] SNF [ ] Jail/Prison [ ] Residential Facility [ ] Other
Household Members: Children < 5 yrs. [ ] Yes [ ] No Elderly [ ] Yes [ ] No Immunocompromised [ ] Yes [ ] No
Known contact to another case? [ ] Yes [ ] No If yes, name of source case _____ County _____
Address/Facility patient is going to _____ Phone _____
Other Locating Information _____
MD / Provider Assuming Care _____ Phone _____
Date / Time / Location of Follow-up Appointment _____

DIAGNOSIS

[ ] Active TB [ ] Suspect Active TB [ ] Pulmonary [ ] Extra pulmonary (site) _____
Symptoms: [ ] Cough (duration ____) [ ] Hemoptysis [ ] Night Sweats [ ] Other
[ ] Weight Loss (_____lbs.) [ ] Fatigue [ ] Fever _____
History of Previous TB Treatment (Where/When/What) _____
Name of Laboratory _____ Phone _____

BACTERIOLOGY RESULTS							
		Initial			Most Recent		
		-1	-2	-3	-1	-2	-3
DATES							
SOURCE							
SMEAR AFB							
CULT	MTB						
	OTHER						

DRUG SUSCEPTIBILITY TESTING DONE [ ] YES [ ] NO
DATE (Specimen Obtained From Patient): _____
DRUG RESISTANCE [ ] YES [ ] NO
TO WHAT DRUGS (Attach Report): _____

OTHER TESTS	DATE PLACED	DATE READ	RESULTS
TUBERCULIN SKIN TEST (PPD)			MM
			MM
CHEST X-RAY (Attach Report)		[ ] CAVITY [ ] INFILTRATE [ ] UNK [ ] NEGATIVE	
F/U CXR (Attach Report)		[ ] STABLE [ ] IMPROVING [ ] WORSE [ ] UNK	

IMMCOMP [ ] YES [ ] NO
IDU [ ] YES [ ] NO ALCOHOL ABUSE [ ] YES [ ] NO
OTHER SUBSTANCE ABUSE [ ] YES [ ] NO

TREATMENT

Adherent [ ] Yes [ ] No Explain: _____
Will case management include directly observed therapy (DOT)? [ ] Yes [ ] No Explain: _____

MEDICATIONS	DOSAGE	DATE STARTED	DATE STOPPED	REASON FOR D/C
1. INH				
2. RIFAMPIN				
3. PYRAZINAMIDE				
4. ETHAMBUTOL				
5.				

COMMENTS (e.g. language spoken, other medical/health issues)

Race
[ ]White
[ ]Black
[ ]American Indian/ Alaskan Native
[ ]Asian or Pacific Islander
Specify _____
[ ]Other _____

Ethnicity
[ ]Hispanic
[ ]Non Hispanic

U S Born
[ ] Yes
[ ] No

Completed by: _____ Phone: _____ Fax: _____ Date: _____