Connecticut Tuberculosis Patient Discharge and Treatment Plan

The *Connecticut Tuberculosis Patient Discharge and Treatment Plan* is a template that may assist with the discharge planning process. It is a collaborative effort between hospital/facility staff, the TB patient, and Local Health Department staff. The purpose of the Connecticut Tuberculosis Patient Discharge and Treatment Plan is to ensure a safe transition for the patient back to a community setting while considering the public's health. It also ensures continuity of care, with the goal of successful treatment outcome. Public Act 95-138 requires that a written discharge or treatment plan be approved by the Local Health Director. It is agreed that this plan provides the best medical and public health care available for this patient. **A TB patient discharge and treatment plan must be faxed to the TB Control Program at 860-730-8271 after all signatures have been obtained.**

Section A. Patient Contact Information

Patient Name:_____ DOB: _____ Record no.:_____

Address:_____ Phone:_____

Hospital Admit Date:_____ Hospital Discharge Date:_____

Client's Emergency Contact:_____ Phone:_____

Address:_____

Section B. Discharge and Treatment Plan

1. Reported to the Local & State Health Departments by: _____ Date:_____

2. Outpatient TB care Physician:_____

Address:_____

Phone:_____ Appointment Date/Time:_____

3. Drugs and Dosages Prescribed: ☐ INH _____ ☐ RIF _____ ☐ PZA _____ ☐ EMB _____

☐ SM _____ ☐ B-6 _____ ☐ Other _____ ☐ Other _____

4. Frequency: ☐ Daily ☐ 3x Weekly ☐ Other _____

(NOTE: Generally, all patients should be on 4 anti-TB drugs until susceptibility results are available.)

5. Therapy Supervision: ☐ Directly observed therapy (DOT) (*ATS Standard of Care)* ☐ Self-administered ☐ Other _____

DOT Provider: _____ Phone: _____

6. Location for DOT:_____ Time: _____ on weekdays

7. Local Public Health Case Manager is: _____ Phone: _____

8. TB-specific education and counseling provided by:_____ Date:_____

9. Obstacles to therapy adherence identified to date: ☐ None

☐ Homelessness ☐ Physical limitation ☐ Substance abuse _____

☐ Cognitive limitation ☐ Mental status ☐ Other _____

Proposed interventions for obstacles identified above: _____

Referral(s) were/will be made on _____ (date):

Agency/Person: _____ Phone:_____

Agency/Person: _____ Phone:_____

Section C. Signatures

The following individuals agree to and approve of above TB Discharge and Treatment Plan ***(All Signatures required)***:

Physician:_____ Date: _____

Patient:_____ Date: _____

Local Health Director or Designee: _____ Date: _____