TUBERCULOSIS PATIENT MANAGEMENT PLAN

FAX in anticipation of discharge:

1. *Health Department for the client's town of residence*
2. *State of CT, TB Control Program, 860-509-7743*

CLIENT NAME_____ DOB _____ RECORD NO. _____

ADDRESS_____ PHONE _____ ADMIT DATE _____ D/C DATE _____

CLIENT'S EMERGENCY CONTACT_____ PHONE_____

ADDRESS_____

The following TB management plan for the client named above has been discussed with the undersigned care providers and client. The care providers agree that this plan is consistent with public health regulation 19a-504c and public act 95-138, requiring a written discharge plan and that plan provide the best medical and public health care available for this client.

This case was reported to the local and state health departments by _____ Date_____

Follow-up TB care physician_____ Phone _____ Appointment date _____

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

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

To be ingested: ☐ DAILY ☐ 2x WEEKLY ☐ 3x WEEKLY ☐ OTHER _____

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

Supervision: ☐ Directly observed (DOT) *Current ATS standard of care* ☐ self-administered ☐ Other _____

DOT Worker(s) will be: _____ (weekdays) Phone _____

_____ (weekends) Phone _____

Site(s) and time(s) for Directly Observed Therapy (DOT):

at: _____ time: _____ on weekdays

if necessary, at: _____ time: _____ on weekends

Local/State Public Health Case Manager is _____ Phone: _____

TB specific education and counseling provided by _____ Date_____

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 _____

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

Physician: _____ Date: _____

Client: _____ Date: _____

Local Health Director or Designee: _____ Date: _____