Connecticut Tuberculosis Patient Discharge and Treatment Plan

CONNECTICUT PUBLIC HEALTH

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 #:__________

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: __________