# TUBERCULOSIS PATIENT DISCHARGE/MANAGEMENT PLAN

Sec. 19a-504c-1. Discharge planning (a) Every hospitalized patient shall have a written discharge plan, which shall be given to the patient or family or representative prior to discharge. (b) The discharge plan shall include but not necessarily be limited to identification of the patient's needs for continued skill care or support services, and the specific resources to be utilized to meet these needs. (c) The discharge plan must be completed on a timely basis so that appropriate arrangements for post hospital care management are made before discharge. (d) The discharge plan is to be developed in collaboration with the patient, or appropriate family or representative and other care givers. (e) The discharge plan shall be approved by the physician of record. (f) The written discharge plan must be signed by the patient and/or family member or representative indicating their understanding of the discharge plan of care. (g) The documentation of the written discharge plan shall be retained as a permanent part of the patient's medical record. (h) Information necessary to ensure the continuity of care will be sent to participating providers, as appropriate, a copy of which will be retained as a permanent part of the patient's medical record. (Effective September 25, 1989)

CLIENT NAME_____ DOB _____ RECORD NO. _____

ADDRESS_____ PHONE _____

ADMIT DATE _____ DISCHARGE DATE _____

CLIENT'S EMERGENCY CONTACT_____ PHONE_____

ADDRESS_____

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

DOT Provider: _____ Phone _____

6. Site for Directly Observed Therapy (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: _____

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

Agency/Person: _____ Phone _____

Agency/Person: _____ Phone _____

The following individuals agree to and approve of above treatment plan *(Signatures):*

Physician: _____ Date: _____

Client: _____ Date: _____

Local Health Director or Designee: _____ Date: _____

*The above TB patient management plan for the client named above has been discussed with the undersigned care providers and client. This plan is consistent with public health regulation 19a-504c and public act 95-138, requiring a written discharge or treatment plan. It is agreed that this plan provides the best medical and public health care available for this client.*

Revised 01/15/19