

Confidential Hospital Discharge Care Plan for Suspect or Confirmed Tuberculosis Case

Approval Request

Telephone: (442) 265-1423

Fax: (442) 265-1474

Patient Name: _____ DOB _____ MR#: _____ If Pulmonary: Dates of three consecutive negative smears _____	Submitted By: _____ Phone: _____ Cell: _____ Facility: _____ Fax#: _____
Discharge to: <input type="checkbox"/> Home <input type="checkbox"/> Shelter <input type="checkbox"/> SNF <input type="checkbox"/> Jail/Prison <input type="checkbox"/> Other: _____	
Discharge address and phone: _____	
Date patient to be discharged: _____ F/U Appt. Date: _____	
Physician agreeing to assume TB Care: _____ Phone#: _____	
Health Care Facility: _____	
Address: _____	

Skin test/QFT: Date _____ Result: _____

Current weight _____ lbs/kg

Current height _____

Discharge TB Medication regimen:
(indicate total daily dose)

INH _____ mg
 Rifampin _____ mg
 Ethambutol _____ mg
 Pyrazinamide _____ mg
 Other _____ mg
 Side Effects _____

Medical complications (specify):

of days of medication supply _____

(Must be sufficient to supply patient until follow-up provider appointment.)

Does the patient have risks that indicate Directly Observed Therapy (DOT)?*

- Mental Impairment
- Homelessness
- HIV
- History of any non-complaint behavior
- Substance Use/Abuse

*Contact TB Control if uncertain about risk.

Contact information/Household composition:

Number of people in household: _____

Are there children age 5 years or younger? Yes No

Are there immunocompromised individuals? Yes No

Tuberculosis Control Only

ICPHD Review-Problems Noted: _____

Action taken before discharged: _____

Reviewed by: _____

Approved by: _____

Discharged Approved:

Yes No

Date Reviewed: _____

Date Approved: _____

The Confidential Morbidity Report for Tuberculosis must be on file at Tuberculosis Control or submitted with this form.

Date Submitted: _____ Faxed By: _____

Imperial County Public Health Department TB Control Program

Confidential Hospital Discharge Care Plan for Suspect or Confirmed Tuberculosis Case Approval Request Instructions

Discharge of a Suspect or Confirmed Tuberculosis Patient

As of January 1, 1994 California Health and Safety Codes mandate that patients suspected or confirmed with tuberculosis may not be discharged or transferred from a health facility (e.g. hospital) without prior approval of the Local Health Officer or designee (i.e., TB Controller). To facilitate a timely and appropriate discharge, the provider should submit a written discharge plan to Tuberculosis Control 1 to 3 days prior to the anticipated discharge. Tuberculosis Control will review the discharge plan for approval.

Health Department Response Plan:

Weekly discharge (Non-holiday 8:00 am- 5:00 pm): The written discharge plan should be submitted by FAX to (442) 265-1474.

Tuberculosis Control staff will review the discharge plan and notify the provider of approval **within 24 hours** or inform the provider of any additional information/action required or needed for approval prior to discharge.

If a home evaluation is required to determine if the environment is suitable for discharge, health department staff will make a visit.

Holiday and Weekend Discharge: All arrangements for discharge should be made in advance when weekend discharge is anticipated. The process outlined above will be followed. If discharge cannot be approved, the patient must be held until the next business day when appropriate arrangements can be made (*To fulfill State requirements for communicable disease reporting, the Confidential Morbidity Report for Tuberculosis must be completed and submitted prior to or concurrently with the Confidential Hospital Discharge Care Plan/Approval Request*).

(NOTE: This form is used for discharge care planning only. Please call Tuberculosis Control Program prior to faxing documents to ensure timely processing.)

Tuberculosis Control Program Contact Information:

Telephone: (442) 265-1423

Fax: (442) 265-1474