Hospital Discharge Plan for Tuberculosis Patients

For all active or suspected TB cases please complete and fax this form to Sacramento Tuberculosis Control at 854-9614; then call and report case to Chest Clinic at 916-874-9597 or 916-874-9823 during business hours of Monday-Friday 8a-5p; otherwise 916-875-5881 after hours.

Source of Referral:	Referring Hospital:	Hosp MR#
Admitted:	Expected discharge date:	Hospital Floor & Room:
Physician Name:	Physician Contact Number:	Return Fax Number:
Patient Name:	Patient DOB:	Insurance Type/ID:

Diagnostic Tests AFB Sputum/other source (x3):	#1: Source:_____ Date:_____ Time:_____ Induced? ☐ Yes ☐ No Smear: ☐ Positive ☐ Negative PCR: ☐ Positive ☐ Negative Rif Resistance: ☐ Detected ☐ Not detected Culture: ☐ Positive ☐ Negative ☐ Pending	#2: Source:_____ Date:_____ Time:_____ Induced? ☐ Yes ☐ No Smear: ☐ Positive ☐ Negative PCR: ☐ Positive ☐ Negative Rif Resistance: ☐ Detected ☐ Not detected Culture: ☐ Positive ☐ Negative ☐ Pending	#3: Source:_____ Date:_____ Time:_____ Induced? ☐ Yes ☐ No Smear: ☐ Positive ☐ Negative PCR: ☐ Positive ☐ Negative Rif Resistance: ☐ Detected ☐ Not detected Culture: ☐ Positive ☐ Negative ☐ Pending
Chest x-ray	Date:	☐ Normal ☐ Abnormal ☐ Non-cavitary on CXR ☐ cavitary on CXR	

TB Medications	**Dose**	**Date started**	**Date stopped**	**Reason for D/C**
Isoniazid (INH)				
Rifampin (RIF)				
Ethambutol (EMB)				
Pyrazinamide (PZA)				
Pyridoxine (PDX)				
Other TB meds				
				Patient weight:_____(REQUIRED)

Labs (REQUIRED)	**Date Drawn:**	**Results:**
AST/ALT		
Creatinine (Cr)		

Non-TB Medications:_____

Allergies: ☐ NKDA ☐ Allergy/rxn: _____

Other disease conditions: ☐ DM ☐ renal failure/dialysis ☐ transplant (type):_____

****Discharge Planning Criteria:** (*please mark all criteria met*)

☐ Three (3) consecutive negative smears (date/time/results above) ☐ PCR (date/time/results above *& required by Sac County for d/c consideration*)

Appropriate multi-drug anti-tuberculosis therapy a minimum of: ☐ 5 days for smear negative cases ☐ two (2) weeks for smear positive cases

Documented clinical and/or radiologic improvement? ☐ clinical improvement ☐ radiologic improvement ☐ No improvement

☐ **Another diagnosis for pulmonary process. Dx**:_____

Planned Discharge Facility:

☐ Home ☐ Group home ☐ Shelter ☐ Skilled Nursing Facility ☐ Other facility ☐ Motel ☐ IJ to County:_____

Discharge Address:_____ Phone #_____

Follow-up plan:

☐ Chest clinic f/u appt (date & time):_____@ 4600 Broadway Suite 1300, Sac, Ca. 95820 Phone #: 916-874-9823

☐ PMD f/u appt (date/time/location):_____ Address and phone of clinic or MD (required for discharge)

☐ Dialysis f/u appts (date/time/location):_____

Address and phone number of dialysis clinic (required for discharge)

COUNTY USE ONLY BELOW THIS LINE

Date Discharge Received?_____ Date responded:_____

Response: ☐ Not Approved for discharge pending:_____

_____

Discharge Re-evaluated (dates):_____

☐ Home Visitation Completed (date)_____ & by PHN:_____

Home Visit Results: ☐ PHN approved home isolation ☐ PHN non-approval for home isolation

☐ NO TB Medications upon discharge ☐ TB Medications in hand @ discharge: _____

☐ Discharge home on isolation until cleared by local Health Department ☒ **Discharge home with copies of radiology studies**

This is not a valid discharge approval until signed by Health Officer or Designee

☐ Sacramento County TB Control Approval ☐ Secondary TB Control Approval

_____ _____

Signature & Date of discharge Approval by Health Officer/designee Signature & Date of discharge Approval by Health Officer/designee