

## Confidential Hospitalized TB Suspect / Discharge Care Plan / Approval Request

<b>Patient Name:</b> _____	<b>Submitted By:</b> _____
D.O.B. ____ / ____ / ____ MR# _____	Phone ( ____ ) _____ Pager ( ____ ) _____
	<b>Facility</b> _____
	Fax # ( ____ ) _____
<b>If Pulmonary: Dates of three consecutive negative smears</b> ____ / ____ / ____ , ____ / ____ / ____ , ____ / ____ / ____	

<b>Discharge to:</b> <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: _____	
<b>Date patient to be discharged</b> ____ / ____ / ____	<b>F/U Appt. Date</b> ____ / ____ / ____
<b>Physician agreeing to assume TB care</b> _____	Phone # ( ____ ) _____
Health Care Facility _____	
Address _____	

**Discharge TB medication regimen:**  
(Indicate total daily dose)

Rifamate® (INH+RIF)\* \_\_\_\_\_ pills/day  
Rifater® (INH+RIF+PZA) \_\_\_\_\_ pills/day  
INH \_\_\_\_\_ mg  
Rifampin \_\_\_\_\_ mg  
Ethambutol\* \_\_\_\_\_ mg  
Pyrazinamide\* \_\_\_\_\_ mg  
Other \_\_\_\_\_ mg  
Side Effects \_\_\_\_\_

\*Current CDC/ATS and Los Angeles County  
TB Control recommendations for treatment of  
uncomplicated TB for 2 months followed by  
INH & RIF for 4 months.

**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
- Homeless
- HIV
- Hx of any non-compliant behavior
- Substance

\*Contact TB Control if uncertain about risk.

**Contact Information/Household composition:**

Number of people in household? \_\_\_\_\_

Are there children age 5 years and younger?  Yes  No

Are there individuals immunocompromised?  Yes  No

**Tuberculosis Control use only:**

DHS Review - Problems Noted \_\_\_\_\_

Action taken before discharge \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date reviewed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Approved by \_\_\_\_\_ Date approved \_\_\_\_ / \_\_\_\_ / \_\_\_\_

<b>Discharge Approved</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No
Date ____ / ____ / ____

The Confidential Tuberculosis Suspect Case Report (H-803) form must be on file at Tuberculosis Control or submitted with this form

**Los Angeles County • Department of Public Health  
Tuberculosis Control Program**

2615 S. Grand Ave. Room 507 Los Angeles, CA 90007  
Phone: 213-744-6160 Fax: 213-749-0926

**Confidential Hospitalized TB Suspect/Case Discharge Care Plan / Approval Request (H- 804) Instructions**

**Discharge of a Suspect or Confirmed Tuberculosis Patient**

As of January 1, 1994, State 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 (i.e., TB Controller).

To facilitate a timely and appropriate discharge, the provider should submit a written discharge plan to Tuberculosis Control 1 to 2 days prior to the anticipated discharge. Tuberculosis Control will review the discharge plan for approval or denial.

**Health Department Response Plan:**

**Weekly discharge (Non holiday 8:00 am- 5:00 pm):** The written discharge plan should be submitted preferably by FAX or mail.

Tuberculosis Control staff will review the discharge plan and notify the provider **within 24 hours** of approval 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. When unusual circumstances necessitate weekend or holiday discharge, the provider will phone the Los Angeles County Operator at (213) 974-1234 and ask to speak with the **Public Health Administrative Officer of the Day** (AOD). A response will usually occur within one hour. The process outlined above will be followed. If the discharge cannot be approved, the patient must be held until the next business day until appropriate arrangements can be made *(to fulfill State requirements for communicable disease reporting, the Confidential Hospitalized Tuberculosis Suspect/Case Report must be completed and submitted prior to or concurrently with the Confidential Hospitalized Tuberculosis Suspect/Case Discharge Care Plan /Approval Request).*

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