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County of San Diego

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PUBLIC HEALTH SERVICES
TUBERCULOSIS CONTROL BRANCH
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Discharge of a Suspect or Confirmed Tuberculosis Patient

As of January 1, 1994, State Health and Safety Codes mandate that patients suspect for or confirmed with TB may not be discharged or transferred without **prior** Health Department approval, regardless of site of disease, level of infectiousness or diagnosis prior to admission.

To facilitate timely and appropriate discharge, the provider should notify the Health Department 1-2 days prior to anticipated discharge to review the discharge criteria.

Health Department Response Plan

Weekday Discharge--Non-Holiday 8:00 a.m. - 5:00 p.m.

Upon our receipt of the discharge plan, which may be sent by FAX (619) 692-5516 or phone (619) 692-8610, the TB Control staff will provide a response within 24 hours, as state law permits.

The TB Control staff will review the plan and notify provider of approval or will inform provider of additional information/action that is needed prior to discharge to obtain approval.

If a home evaluation is needed to determine if the environment is suitable for discharge, the TB Control staff will make a home visit within 3 working days of notification.

If the patient is homeless or there is concern for non-compliance, TB Control staff will interview the patient **prior to discharge**. This interview will take place within one working day of notification to TB Control.

Holiday and Weekend Discharge 8:00 a.m. - 5:00 p.m.

The provider may page TB Control staff on cell phone (619) 540-0194. Response time will usually be within one hour. The process mentioned above will be followed. If the discharge cannot be approved, the patient **MUST** be held until the next business day for appropriate arrangements to be made.

(Note: Use of form on reverse side for discharge care planning only. To fulfill state requirements for disease reporting, TB Suspect Case Form must also be completed.)

TUBERCULOSIS DISCHARGE CARE PLAN

Patient Name: ___________________________

D.O.B:____/____/_____ MR#: ______________

Insurance Source: ________________________

Completed By: ______________________________
(person completing form)

Phone: _________________

Facility: ____________________________________

Date Submitted: ___________________________

Pulmonary TB
Dates of three consecutive negative smears if applicable: ___/___/___ ___/___/___ ___/___/___

Date Patient to be Discharged: _____/___/_____

Discharge to: [ ]Home [ ]Shelter [ ]TB Housing [ ]SNF--DSD/DON:_________________ Phone: ___________

Discharge Address: ____

Discharge Phone#:___________________

Physician Assuming TB Care: _____________________________________ Phone: _______________________

Follow-up appointment date: ____/___/_____ (within 2 weeks of d/c) Time: ________________

Appointment Address: ____

TB Medication at Discharge (Daily Dose)

Weight (kg) ______ Date weighed ____/____/____
Isoniazid ________ mg
Rifampin/Rifabutin ________ mg
Ethambutol ________ mg
Pyrazinamide ________ mg
B6 ________ mg
Other __________________________
____
____

Number of Days Medication Supply ______________
(30 day supply or coverage until follow-up appointment)

All SD County patients to be discharged on
Directly Observed Therapy
❒ Patient informed by CM/SW

❒ CM/SW notified client regarding Home Isolation requirements, if infectious.

--------- FOR TB CONTROL USE ONLY ---------

Confirmed MD appointment if smear (+) at discharge ❒ Name: ________________________________

Problems noted/Action taken before discharge: ___________________________
____

Reviewed by ____

Date of Review ____

Discharge Approved

Yes _____ **No** _____

Date _____/___/______

(SEE REVERSE SIDE FOR INSTRUCTIONS FOR USE)