Discharge Checklist

Patients with active or suspected tuberculosis can only be discharged after ALL of the following have been completed.

Tel. (628) 206-8524    Fax (628) 206-4565

<table>
<thead>
<tr>
<th>Patient Last Name</th>
<th>First</th>
<th>Middle</th>
<th>DOB: mm / dd / yyyy</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

- Hospital Discharge Approval Forms packet faxed to TB Control:
  - Completed Tuberculosis Discharge Approval Form (included in packet, can also be found at: [http://sfcdcp.org/tbhospitaldischarge.html](http://sfcdcp.org/tbhospitaldischarge.html))
  - Discharge Checklist (this document)

- Medical records faxed to TB Control:
  - Physician notes (H&P, Pulm/ID Consult notes, D/C summary)
  - Medication list & dosages (including non-TB medications)
  - MAR of TB meds – to confirm daily observed therapy
  - Diagnostic tests (PPD, AFB smear/culture, molecular tests, pathology)
  - Radiology reports (CXR, CT)
  - Labs (QFT, CBC, comp metabolic, HIV, hepatitis, HbA1c or fasting glucose, uric acid)

- Images from relevant CXRs and/or CTs burned onto CD and given to patient

- Patient seen at TB Clinic (if at ZSFGH), met with the Disease Control Investigator, and/or has a scheduled follow-up appointment at the TB Clinic

- Patient educated about their condition and D/C plan

- TB medication prescribed and filled (medications should be administered in a single daily dose, i.e. not split dosing) – please only dispense what is instructed by TB Control

DO NOT D/C patient until final approval is obtained from TB Control. You will receive confirmation by call/fax within 24 hrs of submitting the above information. If the patient resides outside of SF, please allow at least 48 hrs of turn-around time.

If you have any questions regarding procedures, please contact the San Francisco Tuberculosis Control Program Surveillance Chief, Felix Crespin, ph# 628.206.3398.
MANDATORY REPORT! Per state law Health and Safety Code Sections 121361(a)(1) and 121362, this form must be completed for any patient with active OR suspected TB. Approval of the treatment plan by the TB Control Office must occur prior to transfer or discharge. Please contact the TB Control Office at least 24 hours prior the anticipated discharge time, or 48 hours if patient resides outside SF.

**Section A: Patient Information**

Pt. Name: _______________________________ Alias (if any): ___________ Gender: ☐ Male ☐ Female ☐ Trans

Address: ________________________________________________________

Date of Birth: ___/___/________ Phone: (___) ______________ Primary language: ___________________

Race/Ethnicity: ______________ Country of Origin: ___________________ Date Arrived (in the US): ___/___/____

Occupation: __________________ Medical Insurance: __________________________ Last 4 digits of SS# ______

Emergency Contact: _____________________________________________ Phone: (___) __________

**Section B: Hospital Information**

Date of Admission: ___/___/______ Medical Record No.: __________________________

Institution/Hospital: ___________________ Resident/Attending: ________________________

Room/Location: _________________________ Provider Contact: (___) ______________ (pager/cell/phone)

**Section C: Patient TB Information**

Status: ☐ Lab Confirmed ☐ Suspected (Date of TB Diagnosis: ___/___/_____; Symptom Onset: ___/___/____)

Date Reported to Health Dept: ___/___/______

Immunocompromised: ☐ Yes ☐ No Psychiatric Evaluation: ☐ Yes ☐ No

Substance Abuse: ☐ Yes ☐ No Psychiatric Disability: ☐ Yes ☐ No

Homeless: ☐ Yes ☐ No Cognitive Deficit: ☐ Yes ☐ No

Referrals made for above (e.g. psychiatric, substance abuse, homelessness/social services): ______________________

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last PPD/TST</td>
<td></td>
<td>☐ Pos ___ mm</td>
</tr>
<tr>
<td>QFT/IGRA</td>
<td></td>
<td>☐ Pos  ☐ Neg</td>
</tr>
<tr>
<td>Initial CXR</td>
<td></td>
<td>Attach Report</td>
</tr>
<tr>
<td>Most Recent CXR</td>
<td></td>
<td>Attach Report</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Active cough?</th>
<th>☐ Yes ☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>On treatment for active TB?</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Site of disease:</td>
<td>☐ Pulmonary ☐ Extrapulmonary (specify): ____________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bacteriology: Date</th>
<th>Source</th>
<th>AFB Smear Results</th>
<th>NAAT/PCR</th>
<th>AFB Culture Results (Organism Identified)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>☐ Pos  ☐ Neg</td>
<td>☐ Pos  ☐ Neg  ☐ N/A</td>
<td>☐ Pos  ☐ Neg  ☐ Pending</td>
</tr>
<tr>
<td></td>
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<td>☐ Pos  ☐ Neg</td>
<td>☐ Pos  ☐ Neg  ☐ N/A</td>
<td>☐ Pos  ☐ Neg  ☐ Pending</td>
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<td>☐ Pos  ☐ Neg</td>
<td>☐ Pos  ☐ Neg  ☐ N/A</td>
<td>☐ Pos  ☐ Neg  ☐ Pending</td>
</tr>
</tbody>
</table>
## Section D: Discharge Information

### Drug Regimen

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Other medication</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rifampin</td>
<td></td>
<td>6.</td>
<td></td>
</tr>
<tr>
<td>2. Isoniazid</td>
<td>7.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. B6</td>
<td></td>
<td>10.</td>
<td></td>
</tr>
</tbody>
</table>

### Test Date

<table>
<thead>
<tr>
<th>Test Date</th>
<th>Result</th>
<th>Test Date</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV:</td>
<td></td>
<td>Creatinine:</td>
<td></td>
</tr>
</tbody>
</table>

Patient’s weight: _____ lbs.  Date: _____/_____/______  Anticipated discharge date: _____/_____/______

Discharge to:  
- [ ] Home  
- [ ] Shelter*  
- [ ] SNF*  
- [ ] Jail/Prison  
- [ ] Other (specify)*  

*Please specify name & address: ________________________________

Primary Medical Doctor (PMD): ________________________________  Follow-up appointment: (____/____/____)

Address/Institution: ______________________________________

Phone (____) __________________ Fax (____) ____________________

***To whom should DPH return a copy of this form, “TB Discharge Approval Form,” once Section E is completed?__________________________  FAX (____) ____________________

Fax this form to Chris Keh, M.D., TB Controller, at fax # (628) 206-4565

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## Section E: FOR DPH USE ONLY

Expected adherence to medication:  
- [ ] Good  
- [ ] Intermediate  
- [ ] Poor

Will patient be on DOT?  
- [ ] Yes  
- [ ] No  
If yes, where will DOT be administered: ________________________________

Transportation from hospital/to clinic:  
- [ ] Has personal transport  
- [ ] Needs personal transport  
- [ ] OK for public transport/taxi

Any anticipated future travel:  
- [ ] Yes  
- [ ] No  
If yes, where: ________________________________

Contacts/Household Composition (if known): ________________________________

Discharge or Transfer Approved:  
- [ ] Yes  
- [ ] No

Actions required prior to discharge: ________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Completed by: ________________________________________________  
Name: ___________________________  Title: ___________________________  Date: _____/_____/______

Follow-up TB clinic appointment date: ______/_____/______

TB Clinic: 2460 22nd Street, Building 90, 4th floor, San Francisco, CA 94110 (628) 206-8524

Signature: __________________________________________  Date: _____/_____/______