

ALAMEDA COUNTY PUBLIC HEALTH DEPARTMENT TUBERCULOSIS DISCHARGE TREATMENT PLAN

Prior to anticipated discharge . . . Complete this form in entirety and fax to Alameda County TB Control Program: **510-273-3916**

Patient Name	Date of Birth	Facility
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PART I: DISCHARGE INFORMATION

Anticipated Discharge Date / /	Discharge to: <input type="checkbox"/> HOME <input type="checkbox"/> SKILLED NURSING FACILITY <input type="checkbox"/> SHELTER <input type="checkbox"/> JAIL / PRISON <input type="checkbox"/> OTHER (Specify _____)		
Discharge Address: STREET _____ CITY _____		ZIP CODE _____	COUNTY _____
Name of Medical Provider After Discharge _____		PAGER NUMBER _____	PHONE NUMBER _____
Meds to last until appointment? <input type="checkbox"/> YES <input type="checkbox"/> NO		Follow Up Appointment Date: _____ Time: _____ AM PM	SPECIAL INSTRUCTIONS _____

PART II: DISCHARGE MEDICATIONS / TREATMENT PLAN *(Complete upon discharge)*

CURRENT BACTERIOLOGY: Submit Current Reports					DISCHARGE MEDICATIONS		Weight:
DATE <small>(Month/Day/Year)</small>	SOURCE	SMEAR	CULTURE		MEDICATION	DAILY DOSAGE IN MGMS	START DATE
		+ / -	+ / -	PDG			
					ISONIAZID		
					RIFAMPIN		
					PYRAZINAMIDE		
					ETHAMBUTOL		
					B6		
					OTHER		
					OTHER		
					OTHER		

Current CXR Report Date _____ <input type="checkbox"/> Stable <input type="checkbox"/> Improved <input type="checkbox"/> Worse Describe _____ _____	DOT Recommended? <input type="checkbox"/> YES <input type="checkbox"/> NO DOT To Occur Where? <input type="checkbox"/> Clinic/MD <input type="checkbox"/> Home <input type="checkbox"/> Worksite <input type="checkbox"/> Other _____
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PHN Assessment Received? <input type="checkbox"/> YES <input type="checkbox"/> NO Reviewed? <input type="checkbox"/> YES <input type="checkbox"/> NO	COMPLETED BY: _____	PHONE NUMBER _____ FAX NUMBER _____ DATE _____
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PART III: HEALTH DEPARTMENT REVIEW

Discharge Approved: YES NO Problems Identified: _____

Actions Required Prior to Discharge: _____

Authorized By _____ Date _____

NAME OF HEALTH OFFICER / DESIGNEE

Alameda County Public Health Department Tuberculosis Control Program

Tuberculosis Discharge Treatment Plan

Discharge of a Suspected or Confirmed Tuberculosis Patient

As of January 1, 1994, California State Health and Safety Codes mandate that patients suspected of or confirmed as having TB **may not be discharged or transferred without prior Health Department approval**. To facilitate timely and appropriate discharge, the provider should notify the Health Department 1-2 days prior to anticipated discharge date to review the discharge criteria. (See below.)

Tuberculosis Control Program (TBC) Response Plan

For Weekday Discharge – Non Holiday: Monday – Friday: 8:30 – 4:30pm

Upon receipt of a **completed** discharge request form, TB Control staff will provide a response within 24 hours. To expedite your request, please include **all laboratory and/or radiology reports**.

TBC staff will review the request and notify the submitter of approval, *or* will inform the submitter if additional information or action is required prior to discharge approval. If a home evaluation is needed to determine if the environment is suitable for discharge, the TBC staff will make a home visit within (1) working day of notification.

Holiday and Weekend Discharge

If you anticipate a discharge on a weekend or holiday, please contact the TB Control Program immediately.

In all instances, an accurately completed Discharge/Transfer Treatment Plan must be submitted at least 24 hours prior to consideration for approval for discharge or transfer. If these criteria cannot be satisfied, discharge cannot be approved and the patient **MUST** be held until the next business day for appropriate arrangements to be made.

FAX NUMBER: (510) 273-3916 TB Medical Consultation: (510) 667-3054

Main TB Control Program: (510) 667-3096 *or visit our website: www.acphd.org*