



WARD 94 – SF GENERAL HOSPITAL
San Francisco, CA 94110
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Checklist for Approval of Hospital Discharge and Treatment Plan for Patients with Suspected or Confirmed Tuberculosis

Patient's Name:

Last

First

M.I.

Date of Diagnosis: _____ Date of Admission: _____

Yes

No

- 1. TB Patient Treatment and Follow-up Plan
- 2. Disease Control Investigator (DCI) Home Assessment Completed and Received
- 3. Discharge Criteria Met
- 4. DOT recommended
- 5. Legal Order Served (if yes, copy of order attached)
- 6. Treatment Plan Approved

_____/For Dr. Kawamura

TB Controller/Health Officer

Date

Checklist-Approval of HospDischarge&TXPlan-042211.doc



GUIDELINES FOR DISCHARGE OF TUBERCULOSIS PATIENTS AND SUSPECTS

I. General Considerations

Many tuberculosis (TB) patients are never hospitalized. The greatest risk of transmission occurs prior to initiation of treatment. Seventy-five percent of all people who are acid fast bacillus (AFB) sputum smear positive will remain so for at least 2 weeks, with the majority remaining positive for 4 to 6 weeks. Therefore, while it is realized that it is generally not practical or necessary to keep all patients hospitalized until 3 consecutive sputum smear are negative, other considerations must be evaluated. These include the likelihood the patient will adhere to treatment and isolation precautions; the likelihood of transmission to others (which includes not only the infectivity of the patient but the number of new contacts); and the likelihood and severity of disease in those who may become infected.

Infectivity is related to several clinical characteristics: pulmonary or laryngeal, involvement; symptoms of cough or sneeze; positive sputum smear; cavitation on chest x-ray; length of appropriate therapy; and ability and willingness to cover the mouth when coughing or sneezing. In general, a person with TB likely is infectious if cough is present, sputum smears are positive, and therapy either has just started or is not eliciting a clinical response. However, the risk of transmission from a person with TB on appropriate therapy showing clinical improvement (reduction of cough, fever, and AFB on smear; and improvement in chest x-ray) is substantially reduced after 2 weeks on therapy.

II. Sputum Smear Positive Pulmonary Tuberculosis and Laryngeal Tuberculosis

A. Criteria for discharge to home, with no high risk individuals* in the home:

1. The patient has been started on an appropriate** multiple drug regimen.
2. The patient is stable.
3. The patient understands and can comply with home isolation (i.e., will not leave home or have unexposed visitors without wearing a mask).
4. A plan for ongoing follow up and treatment has been established, and directly observed therapy (DOT) considered.

B. Criteria for discharge to home, with high risk individuals * in the home:

1. The patient has been on an appropriate ** multiple drug regimen for 1 week, or longer if indicated.
2. The patient is clinically improving.

3.
 - a) If the high risk individuals already have been exposed to the patient, then 3 consecutive sputum AFB smears taken on different mornings must show a decrease in numbers of AFB.
 - b) If a previously unexposed high risk individual enters the household while the patient is hospitalized, then 3 consecutive sputum AFB smears taken on different mornings must be negative.
 4. All previously exposed high-risk individuals, including children less than 1 year of age, have been considered for prophylaxis.
 5. The patient understands and can comply with home isolation (i.e., will not leave home or have unexposed visitors without wearing a mask).
 6. A plan for ongoing follow up and treatment has been established *** and directly observed therapy (DOT) considered.
- C. Criteria for discharge to a high-risk setting (i.e., prison, jail, hospital, skilled nursing facility, nursing home, HIV communal housing, drug treatment program, homeless shelter, migrant camp, dormitory, or other group setting):
1. The patient has been on an appropriate ** multiple drug regimen for 2 weeks.
 2. The patient is clinically improving.
 3. Preferably, the patient has had 3 consecutive negative sputum AFB smears taken on 3 different mornings, but at a minimum, 3 consecutive smears must show a decrease in numbers of AFB.
 4. A plan for ongoing close follow up and treatment has been established *** and DOT considered.
- III. Pulmonary Tuberculosis with Negative Sputum Smears and/or Extrapulmonary Tuberculosis
- A. Criteria for discharge:
1. The patient has been started on an appropriate ** multiple drug regimen.
 2. The patient is stable.
 3. If the patient has pulmonary TB, he/she has had at least 3 consecutive sputum AFB smears on different days that have been negative.
 4. A plan for ongoing follow up and treatment has been established***
 5. If being discharged to a high risk setting, the patient has received at least 4 days of an appropriate ** multiple drug regimen.

* The decision as to whether or not high risk individuals are in the household should be based on Disease Control Investigator (DCI) assessment, and includes children less than 1 year of age and immunocompromised people (those with HIV infection, diabetes mellitus, hematologic malignancy, end stage renal disease, chronic under-nutrition; or those who have a history of prolonged steroid therapy, immunosuppressive therapy, intravenous drug use, or substantial rapid weight loss). Of these, children less than 1 year of age and those with HIV infection are considered highest risk.

** The regimen should be consistent with the most recent American Thoracic Society/CDC guidelines (see reference A).

*** The plan should include the physician who will provide follow up care, date(s) of follow up appointments, the prescription or dispensing of sufficient medications until the next appointment, and Directly Observed Therapy (DOT) if needed.

IV. References

- A. Bass JB Jr, Farer LS, Hopewell PC, et al. Treatment of Tuberculosis and Tuberculosis Infection in Adults and Children. *Am J Respir Crit Care Med.* 1994; 149:1359-1374.
- B. California Department of Health Services TB Control Branch. Guidelines for Placement of Tuberculosis Patients into High Risk Settings. 9/8/92.
- C. CDC. Draft Guidelines for Preventing the Transmission of Tuberculosis in Health-Care Facilities, Second Edition. *Federal Register.* 1993;58:52810-52854.
- D. CDC. Prevention and Control of Tuberculosis in Correctional Institutions: Recommendations of the Advisory Committee for the Elimination of Tuberculosis. *MMWR.* 1989;38:313-325.
- E. CDC. Prevention and Control of Tuberculosis in Facilities Providing Long-Term Care to the Elderly. *MMWR* 1990;39:7-20.
- F. Farer LS, Flynn JP, Reza RJ, et al. Control of Tuberculosis. *Am Rev Resp Dis.* 1983;128:336-342.

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Treatment and Follow-up Plan Summary

PATIENT INFORMATION

NAME: _____ ALIAS: _____
LAST FIRST MI LAST FIRST MI

ADDRESS PRIOR TO ADMISSION: _____
STREET CITY ZIPCODE COUNTY

ADDRESS AFTER DISCHARGE: _____
STREET CITY ZIPCODE COUNTY

PHONE NUMBER AFTER DISCHARGE: _____ OCCUPATION: _____

SEX: _____ AGE: _____ DATE OF BIRTH: ____/____/____ SOCIAL SECURITY NUMBER: _____

RACE/ETHNICITY:

- WHITE NON-HISPANIC
- BLACK NON-HISPANIC
- HISPANIC
- NATIVE AMERICAN/ALASKAN NATIVE
- ASIAN/ PACIFIC ISLANDER (SPECIFY: _____)
- OTHER (SPECIFY: _____)

PRIMARY LANGUAGE: _____ COUNTRY OF BIRTH: _____

DATE ARRIVED IN U.S. (MONTH/YEAR): _____ / _____

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____

LEGAL GUARDIAN (IF APPLICABLE): _____

PAROLE OFFICER (IF APPLICABLE): _____

NAME	PHONE NUMBER
NAME	PHONE NUMBER
NAME	PHONE NUMBER

HOSPITALIZATION INFORMATION

NAME OF INSTITUTION: _____ MEDICAL RECORD NUMBER: _____

DATE OF ADMISSION: ____/____/____ BOOKING NUMBER (IF APPLICABLE): _____

MEDICAL PROVIDER: _____

IMMUNOCOMPROMISE? YES NO PSYCHIATRIC DISABILITY? YES NO

SUBSTANCE ABUSE? YES NO HOMELESS? YES NO

PSYCHIATRIC EVALUATION? YES NO (Psychiatric evaluation is recommended if there is psychiatric disability or substance abuse)

IF YES, RECOMMENDATIONS/REFERRALS: _____

SOCIAL SERVICES EVALUTION? YES NO (Social services eval is recommended if there is psychiatric disability, s/a, or homelessness)

IF YES, RECOMMENDATIONS/REFERRALS: _____

MEDICATION ALLERGIES (LIST): _____

PATIENT TB INFORMATION

DATE OF SYMPTOM ONSET: ____/____/____ DATE OF DIAGNOSIS: ____/____/____

REPORTED TO HEALTH DEPARTMENT? YES NO DATE: ____/____/____

STATUS: SUSPECT DEFINITE

SITE: PULMONARY LARYNGEAL EXTRAPULMONARY (SPECIFY: _____)

BACTERIOLOGY (Include all specimens collected during current admission):

DATE (MONTH/DAY/YEAR)	SOURCE/SITE	AFB SMEAR RESULTS	AFB CULTURE RESULTS	ORGANISM(S) IDENTIFIED	SUSCEPTIBILITY RESULTS	LAB PERFORMING TEST

INITIAL CHEST X-RAY: DATE: ____/____/____

RESULTS: CAVITARY NONCAVITARY NORMAL

MOST RECENT FOLLOW-UP

CHEST X-RAY: DATE: ____/____/____

RESULTS: IMPROVED STABLE WORSE NOT DONE

MOST RECENT

TUBERCULIN TEST: DATE: ___/___/___ TYPE: MANTOUX MULTIPLE PUNCTURE
RESULTS: ___MM INDURATION CONTROLS USED? YES NO
COUGH SPUTUM PRODUCTION? YES NO
PRIOR TB DRUG ADHERENCE: GOOD POOR UNKNOWN NOT APPLICABLE
PRIOR TB DRUG RESISTANCE: YES NO UNKNOWN NOT APPLICABLE
CURRENT TB DRUG REGIMEN:

Table with 3 columns: DATE STARTED, MEDICATION (INH, RIF, PZA, EMB, SM, OTHER SPECIFY), DOSAGE. Contains 4 empty rows for data entry.

DISCHARGE INFORMATION

ANTICIPATED DISCHARGE DATE: ___/___/___
DISCHARGE TO:
 HOME SHELTER SKILLED NURSING FACILITY JAIL/PRISON OTHER (SPECIFY: _____)
MEDICAL PROVIDER AFTER DISCHARGE: _____
NAME PHONE NUMBER
ADDRESS

FOLLOW-UP APPOINTMENT DATE: ___/___/___ :___AM/PM

DISCHARGE DRUG REGIMEN (All medications):

Table with 4 columns: MEDICATION, DOSAGE, ANTICIPATED LENGTH OF TREATMENT, NUMBER PRESCRIBED/DISPENSED. Contains 5 empty rows for data entry.

ANTICIPATED ADHERENCE TO TB MEDS AFTER DISCHARGE: GOOD INTERMEDIATE POOR
WILL THE PATIENT BE ON DIRECTLY OBSERVED THERAPY (DOT)? YES NO
IF YES, WHERE WILL DOT BE ADMINISTERED? _____
HOW OFTEN WILL DOT BE ADMINISTERED? DAILY BIWEEKLY OTHER (SPECIFY: _____)
CONTACT EXAMINATION TO BE DONE BY: HEALTH DEPARTMENT PMD
HOUSEHOLD COMPOSITION: NEWBORN/CHILD UNDER 1 YEAR IMMUNOCOMPROMISED PERSON
NUMBER OF CHILDREN: _____ NUMBER OF ADULTS: _____

HOSPITAL DISCHARGE PLANNER: _____
NAME PHONE NUMBER
FAX REPLY TO: _____
NAME TITLE FAX NUMBER
COMPLETED BY: _____
NAME TITLE PHONE NUMBER DATE

PLEASE FAX TO MASAE KAWAMURA, MD, TB CONTROL OFFICER, AT (415) 206-4565

HEALTH DEPARTMENT REVIEW

DISCHARGE APPROVED: YES NO
PROBLEMS IDENTIFIED: _____
ACTIONS REQUIRED PRIOR TO DISCHARGE: _____
COMPLETED BY: _____
NAME TITLE DATE