

## City and County of San Francisco

Dept of Public Health  
TB Control Division

WARD 94 - SF GENERAL HOSPITAL

SF, CA 94110

Tel: (415) 206-8524

Fax: (415) 206-4565

Checklist for Approval of Hospital Discharge and Treatment Plan for Patients with  
Suspected or Confirmed TuberculosisPatient's Name: \_\_\_\_\_  
(Last First M.I.)

Date of Diagnosis: \_\_\_\_\_ Date of Admission \_\_\_\_\_

- | Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. TB Patient Treatment and Follow-up Plan                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Disease Control Investigator (D.C.I.) Home Assessment Completed and Received |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Discharge Criteria Met   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. DOT recommended  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Legal Order served (if yes. Copy of order attached)                          |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Treatment Plan Approved  |

\_\_\_\_\_  
/For Dr. Kawamura  
T.B. Controller/Health Officer\_\_\_\_\_  
Date

**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 ZIP CODE COUNTY  
 ADDRESS AFTER DISCHARGE \_\_\_\_\_  
 STREET CITY ZIP CODE COUNTY  
 PHONE NUMBER AFTER DISCHARGE \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
 SEX \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_  
 RACE/ETHNICITY:  
 WHITE NON-HISPANIC  NATIVE AMERICAN/ALASKAN NATIVE  
 BLACK NON-HISPANIC  ASIAN/PACIFIC ISLANDER (SPECIFY \_\_\_\_\_)  
 HISPANIC  OTHER (SPECIFY \_\_\_\_\_)  
 PRIMARY LANGUAGE \_\_\_\_\_ COUNTRY OF BIRTH \_\_\_\_\_  
 DATE ARRIVED IN US (MONTH/YEAR) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 PERSON TO NOTIFY IN CASE OF EMERGENCY \_\_\_\_\_  
 NAME PHONE NUMBER  
 LEGAL GUARDIAN (IF APPLICABLE) \_\_\_\_\_  
 NAME PHONE NUMBER  
 PAROLE OFFICER (IF APPLICABLE) \_\_\_\_\_  
 NAME PHONE NUMBER

**HOSPITALIZATION INFORMATION**

NAME OF INSTITUTION \_\_\_\_\_ MEDICAL RECORD NUMBER \_\_\_\_\_  
 DATE OF ADMISSION \_\_\_\_/\_\_\_\_/\_\_\_\_ BOOKING NUMBER (IF APPLICABLE) \_\_\_\_\_  
 MEDICAL PROVIDER \_\_\_\_\_  
 NAME PHONE NUMBER  
 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 EVALUATION:  YES  NO  
 (SOCIAL SERVICES EVALUATION IS RECOMMENDED IF THERE IS PSYCHIATRIC DISABILITY, SUBSTANCE ABUSE, 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 (LAST UNTESTED WITH RESULT)	LAB PERFORMING TEST

INITIAL CHEST XRAY: DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
 RESULTS:  CAVITARY  NONCAVITARY  NORMAL  
 MOST RECENT FOLLOW UP CHEST XRAY: DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
 RESULTS:  IMPROVED  STABLE  WORSE  NOT DONE  
 MOST RECENT TUBERCULIN TEST: DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
 TYPE:  MANTOUS  MULTIPLE PUNCTURE  
 RESULTS: \_\_\_\_\_ MM INDURATION  
 CONTROLS USED?  YES  NO



**SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH**

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

DATE STARTED	MEDICATION (INH,RIF,PZA,EMB,SM,OTHER SPECIFY)	DOSAGE

**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)

MEDICATION	DOSAGE	ANTICIPATED LENGTH OF TREATMENT	NUMBER PRESCRIBED /DISPENSED

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 IS 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