City and County of San Francisco
Department of Public Health

Tuberculosis Control Section
Chris Keh, M.D. – TB Controller

Discharge Checklist

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

Tel. (415) 206-8524 **Fax** (415) 206-4565

_____ _____

Patient Last Name First Middle DOB: mm / dd / yyyy

❑ 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)
- **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# 415.206.3398.

City and County of San Francisco

Department of Public Health TB Control Section

Patient ID

Tuberculosis Discharge Approval Form

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): _____

Test	Date	Result	
Last PPD/TST		❑ Pos___mm	❑ Neg
QFT/IGRA		❑ Pos	❑ Neg
Initial CXR		**Attach Report**	
Most Recent CXR		**Attach Report**	

Active cough? ❑ Yes ❑ No

On treatment for active TB? ❑ Yes ❑ No

Site of disease: ❑ Pulmonary ❑ Extrapulmonary (specify): _____

Bacteriology: Date	**Source**	**AFB Smear Results**	**NAAT/PCR**	**AFB Culture Results (Organism Identified)**
		❑ Pos ❑ Neg	❑ Pos ❑ Neg ❑ N/A	❑ Pos ❑ Neg ❑ Pending
		❑ Pos ❑ Neg	❑ Pos ❑ Neg ❑ N/A	❑ Pos ❑ Neg ❑ Pending
		❑ Pos ❑ Neg	❑ Pos ❑ Neg ❑ N/A	❑ Pos ❑ Neg ❑ Pending

Section D: Discharge Information

Drug Regimen start date (mm/dd/yy) _____ / _____ / _____

Medication	Dosage	Other medication	Dosage
1. Rifampin		6.	
2. Isoniazid		7.	
3. Pyrazinamide		8.	
4. Ethambutol		9.	
5. B6		10.	

Test Date	Result	Test Date	Result
HIV:		Creatinine:	

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 # (415) 206-4565

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 (415) 206-8524

Signature: _____ Date: _____ / _____ / _____