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HEALTH AND HUMAN SERVICES AGENCY

PUBLIC HEALTH SERVICES
TUBERCULOSIS CONTROL BRANCH
3851 ROSECRANS ST., Ste 128, SAN DIEGO, CA 92110
(619) 692-5565 FAX (619) 692-5650

Community Epidemiology
Emergency & Disaster Medical Services
HIV/STD Hepatitis
Immunization
Maternal, Child and Family Health Services
Public Health Laboratory
Public Health Nursing/Border Health
TB Control & Refugee Health
Vital Records

Discharge of a Suspect or Confirmed Tuberculosis Patient

As of January 1, 1994, State Health and Safety Codes mandate that patients suspect for or confirmed with TB may not be discharged or transferred without **prior** Health Department approval, regardless of site of disease, level of infectiousness or diagnosis prior to admission.

To facilitate timely and appropriate discharge, the provider should notify the Health Department 1-2 days prior to anticipated discharge to review the discharge criteria.

Health Department Response Plan

Weekday Discharge--Non-Holiday 8:00 a.m. - 5:00 p.m.
Upon our receipt of the discharge plan, which may be sent by FAX (619) 692-5516 or phone (619) 692-8610, the TB Control staff will provide a response within 24 hours, as state law permits.

The TB Control staff will review the plan and notify provider of approval or will inform provider of additional information/action that is needed prior to discharge to obtain approval.

If a home evaluation is needed to determine if the environment is suitable for discharge, the TB Control staff will make a home visit within 3 working days of notification.

If the patient is homeless or there is concern for non-compliance, TB Control staff will interview the patient **prior to discharge**. This interview will take place within one working day of notification to TB Control.

Holiday and Weekend Discharge 8:00 a.m - 5:00 p.m.
The provider may page TB Control staff on cell phone (619) 540-0194. Response time will usually be within one hour. The process mentioned above will be followed. If the discharge cannot be approved, the patient **MUST** be held until the next business day for appropriate arrangements to be made.

(Note: Use of form on reverse side for discharge care planning only. To fulfill state requirements for disease reporting, TB Suspect Case Form must also be completed.)

TUBERCULOSIS DISCHARGE CARE PLAN

Patient Name: _____ Submitted By: _____

D.O.B: ___/___/____ MR#: _____ Phone: _____ Pager: _____

Payor Source: _____ Facility: _____

Pulmonary TB
Dates of three consecutive negative smears ___/___/____ ___/___/____ ___/___/_____

Date Patient to be Discharged: ____/___/_____

Discharge to: [ ] Home [ ] Shelter [ ] SNF/BC [ ] Jail/Prison [ ] Other _____

Discharge Address: _____

Discharge Phone#: _____ SNF Contact: _____ Phone: _____

Physician Assuming TB Care: _____ Phone: _____

Follow-up appointment date: ___/___/____ Time: _____

TB Medication at Discharge Wt: _____
INH _____ mg
Rifampin _____ mg
Ethambutol _____ mg
Pyrazinamide _____ mg
B6 _____ mg
Other _____
HAART _____

Number of Days Medication Supply _____
(3-5 days pills not script)

All SD County patients to be discharged on
Directly Observed Therapy

Contact Information/Household Composition
People in Household #_____
Children < 4 years old #_____
Any Immunocompromised individuals? _____

FOR TB CONTROL USE ONLY

DHS Review - Problems noted _____ **Discharge Approved**

Action taken before discharge _____ **Yes** _____ **No** _____

Reviewed by _____ **Date** ____/___/_____

Date of Review _____

(SEE REVERSE SIDE FOR INSTRUCTIONS FOR USE)