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## 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: _____

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

Insurance Source: _____

Completed By: _____
(person completing form)

Phone: _____

Facility: _____

Date Submitted: _____

**Pulmonary TB**
Dates of three consecutive negative smears if applicable: ___/___/___ ___/___/___ ___/___/___

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**Date Patient to be Discharged: ___/___/____**

Discharge to: [ ]Home [ ]Shelter [ ]TB Housing [ ]SNF--DSD/DON:_____ Phone: _____

Discharge Address: _____

Discharge Phone#:_____

Physician Assuming TB Care: _____ Phone: _____

Follow-up appointment date: __/___/___ (within 2 weeks of d/c) Time: _____

Appointment Address: _____

TB Medication at Discharge (Daily Dose)

Weight (kg) _____ Date weighed __/___/___
Isoniazid _____ mg
Rifampin/Rifabutin _____ mg
Ethambutol _____ mg
Pyrazinamide _____ mg
B6 _____ mg
Other _____
_____
_____

Number of Days Medication Supply _____
(30 day supply or coverage until follow-up appointment)

**All SD County patients to be discharged on Directly Observed Therapy**
**❒ Patient informed by CM/SW**

**❒ CM/SW notified client regarding Home Isolation requirements, if infectious.**

***--------- FOR TB CONTROL USE ONLY ---------***

**Confirmed MD appointment if smear (+) at discharge ❒ Name:** _____

**Problems noted/Action taken before discharge:** _____

_____

**Discharge Approved**
**Yes** _____ **No** _____

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

**Date of Review** _____

*(SEE REVERSE SIDE FOR INSTRUCTIONS FOR USE)*