



County of San Diego

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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: _____

Submitted By: _____

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

Phone: _____ Pager: _____

Insurance Source: _____

Facility: _____

Pulmonary TB

Dates of three consecutive negative smears if applicable: ___ / ___ / ___ ___ / ___ / ___ ___ / ___ / ___

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: _____

Email: _____

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 _____ 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

HAART _____

Household Information for smear (+) cases only

People in Household # _____ Case Manager notified client regarding Home Isolation requirements

Children < 5 years old # _____

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

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

TBC Review - Problems noted _____

Discharge Approved

Action taken before discharge _____

Yes _____ No _____

Reviewed by _____

Date ___ / ___ / ___

Date of Review _____

(SEE REVERSE SIDE FOR INSTRUCTIONS FOR USE)

