DC care plan is only valid for 24 hours from the date of approval

COUNTY OF LOS ANGELES
Public Health
Tuberculosis Control Program

Request for Hospital/Discharge/Transfer Approval Form (H-804)

TEL (213) 745-0800 | FAX (213) 749-0926(Please fax)
AFTER HOURS Call (213) 974-1234

Patient Name:		Submitted By:	
D.O.B.:	MR#:	Phone:	Fax:

☐Pulmonary TB ☐Extrapulmonary TB (specify site):

☐ **Smear-positive disease**: at least 14 days of an effective multidrug treatment regimen by Directly observed Therapy (DOT)* and clinical evidence of improvement or stability. No high suspicion for resistance to core agents.

☐ **Smear-negative disease**: at least 5 days of an effective multidrug treatment regimen by DOT and clinical evidence of improvement or stability. No high suspicion for resistance to core agents.

* For patients with AFB smear-positive disease without access to DOT, de-isolation recommendations may incorporate fulfillment of bacteriologic treatment milestones such as sputum AFB smear-conversion.

Three (3) consecutive AFB smear sputum (collected at least 8 hours apart, one of which should be induced or early morning).
Dates: _____ Neg/Pos, _____ Neg/Pos, _____Neg/Pos ☐Expectorated ☐RT Induced **(submit AFB lab results)**

Discharge to: ☐Home ☐TB Housing ☐Other: _____
TB Care Follow up: ☐DPH ☐Private Medical Provider
Discharge Address: _____
Phone: _____
Date patient to be discharged: _____ Follow-up Appointment Date: _____ Time: _____
Name of Provider assuming TB care: _____ Phone: _____
Hospital notified the treating provider of TB diagnosis and isolation status: ☐ Yes Please initial: _____
Health Care Facility: _____
Address: _____

Discharge TB medication regimen:
(Indicate total daily dose)

INH	_____mg
Rifampin	_____mg
Rifabutin	_____mg
Ethambutol	_____mg
Pyrazinamide	_____mg
Pyridoxine	_____mg
Other	_____
Other	_____
Other	_____

# of days of medication supply: _____
Must provide patient with sufficient supply of medication (in hand), not a Rx, until follow-up provider appointment

Medical complications *(specify)* / **Comments:**

Is patient ambulatory:
☐Yes ☐Self ☐With Assist
☐No

Please attach latest MD notes (vital signs and latest LFTs, BUN/CBC). TBCP will review and disposition within 24 hours of notification.

Any changes to the plan (i.e. change of discharge address, provider, medication regimen, infectious status) necessitates submission of a revised discharge care plan. The confidential Tuberculosis Suspect Report (H-803) form must be on file at Tuberculosis Control or submitted with this form.

Please sign if the patient is medically stable: _____ Date: _____

Tuberculosis Control Program use only:

Other Indicators for Services in DPH
- ☐ People with HIV infection
- ☐ Current substance use disorder
- ☐ Person experiencing homelessness
- ☐ History of previous TB disease
- ☐ Lab results showing resistance to one or more anti-TB drugs
- ☐ Incarceration with current episode of TB
- ☐ Failure to respond to anti-TB therapy
- ☐ Non-daily anti-TB regimen
- ☐ Nonadherence to anti-TB regimen during current episode of TB disease
- ☐ On Health Officer Order
- ☑ Patient without adequate health insurance coverage for all required components of outpatient TB care
- ☐ Congregate living without nursing support
- ☐ Inability to care for oneself without strong caregiver support
- ☐ Age under 5-years-old
- ☐ Transient residency in LA County

Date of Effective Regimen:	
Date of Effective Regimen:	
Date of Discharge/Transfer:	
Missed Daily Doses:	
Total Doses of TB Medications:	

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Problems/Action:

Reviewed by: _____ Date reviewed: _____

Approved by: _____ Date approved: _____

Discharge Approved
☐Yes ☐No
Date: _____

Los Angeles County Department of Public Health
Tuberculosis Control Program

Tuberculosis Control Program Headquarters
123 W. Manchester Blvd. Inglewood, CA 90301
Phone: 213-745-0800 Fax: 213-749-0926

Hospital Discharge/Transfer Approval Request (H- 804) Instructions

Discharge of a Suspect or Confirmed Tuberculosis Patient:

As of January 1, 1994, State Health and Safety Codes mandate that patients suspected or confirmed with tuberculosis may not be discharged or transferred from a health facility (e.g. hospital) without prior approval of the Local Health Officer (i.e., TB Controller).

To facilitate a timely and appropriate discharge, the provider (or the designee, i.e. RN, CM, DC coordinator, etc.) should submit a written discharge plan to Tuberculosis Control Program 1 to 2 business days prior to the anticipated discharge. Tuberculosis Control Program will review the discharge plan for approval or denial.

Health Department Response Plan:

Weekday discharge (Non holiday 8:00 am- 5:00 pm): The written discharge plan should be completed in its entirety and submitted by FAX.

Tuberculosis Control Program staff will review the discharge plan and, **within 24 hours**, notify the provider of approval or request additional information/actions required, before the patient can be discharged or transferred.

All AFB smear positive pulmonary TB suspects require a home evaluation, to determine if the environment is suitable for discharge. A Community Field Services (CFS) Public Health Nurse has three (3) business days to complete an in-person visit to verify discharge address and assess for high-risk contacts. Tuberculosis Control Program Liaison will inform the primary team of the status of the home evaluation, once completed.

Weekend and Holiday Discharge: All arrangements for discharge should be made in advance when weekend discharge is anticipated. When unusual circumstances necessitate weekend or holiday discharge, the provider will phone the Los Angeles County Operator at (213) 974-1234 and ask to speak with the **Public Health Administrative Officer of the Day** (AOD). A response will usually occur within one hour. The process outlined above will be followed. If the discharge cannot be approved, the patient must be held until the next business day until appropriate arrangements can be made.

(NOTE: This form is used for discharge care planning only.)