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

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 Case 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:

Potential barriers to TB therapy adherence
☐Experiencing homelessness
☐Substance use disorder
☐History of nonadherence to medical treatment
☐HIV
☐Other
☐ No insurance
☐ Drug Resistant

Relative Indicators(s) for Services in DPH Clinic:
☐Congregate living without Nursing Support
☐Inability to care for oneself without strong caregiver support
☐Age under 5 years
☐Transient residency in LA County
☐Other

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

☐PMD Letter Requested

DC care plan valid only 24 hrs from approval date

Problems/Action: ____
____
____
____
____

Reviewed by: ______________________ Date reviewed: ______________

Approved by: ______________________ Date approved: ______________

Discharge Approved
☐Yes ☐No
Date: __________

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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.)