COUNTY OF LOS ANGELES
Public Health
Tuberculosis Control Program

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

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

Patient Name: _____ Submitted By: _____
D.O.B.: _____MR#: _____ Phone: _____Fax: _____
Please sign if the patient is medically stable: _____

☐Pulmonary TB ☐Extrapulmonary TB _____ (specify site)

☐**High-risk settings** (e.g. health care facility, nursing home, congregate living, drug treatment program, homeless shelter, jail, dialysis center, other settings with children ages 5 and younger or persons with compromised immunity). Three (3) consecutive AFB smear negative sputum (collected at least 8 hours apart, one of which should be induced or early morning. Dates: _____
_____ _____ ☐Induced ☐RT Induced
Please submit AFB lab results. Smear positive patient will also need to complete 14 days of TB medication. If smear negative 5 days.

☐**Low-risk setting**, sputum clearance not necessary, home isolation instructions provided (if smear positive)

Discharge to: ☐Home ☐TB Housing ☐Other: _____
TB Care Follow up: ☐DPH ☐Community Medical Provider ☐ Community Medical Provider Letter requested
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	_____

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

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

Medical complications *(specify):*
_____
_____
_____
_____
_____

Potential barriers to TB therapy adherence
☐Experiencing homelessness
☐Substance use disorder
☐History of nonadherence to medical treatment
☐HIV
☐Other

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

Comments:
_____
_____
_____
_____
_____

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

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

Tuberculosis Control Program use only:

Problems/Action: _____
_____
_____
_____

Dose Count: _____

Reviewed by: _____ Date reviewed: _____

Approved by: _____ Date approved: _____

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

Discharge Approved
☐Yes ☐No
Date: _____

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.

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 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.)