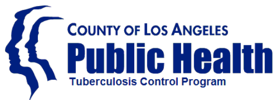

Request for Hospital Discharge/Transfer Approval Form (H-804)

(Please call before faxing)
TEL (213) 745-0800 FAX (213) 749-0926
AFTERHOURS Call (213) 974-1234

Patient Name: ______________________ Submitted By: ______________________

D.O.B.: ____________ MR#: ____________ Phone: ____________ Pager: ____________

Fax: ______________________

☐ 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 under 5 years of age or persons with compromised immunity). Dates of three (3) consecutive AFB smear negative sputum (collected at least 8 hours apart, one of which should be induced or early morning) ___/___/___ ___/___/___ ___/___/___
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 ☐ SRO ☐ SNF ☐ Olive View Inpatient Isolation Unit ☐ Other ____________

Discharge Address: ______________________ Phone: ____________

City, State Zip Code: ______________________

Date patient to be discharged: ___/___/___ Follow up Appointment Date: ___/___/___ Time: ________

Physician assuming TB care: ______________________ Phone: ____________

Health Care Facility: ______________________

Address: ______________________

Discharge TB medication regimen:
(Indicate total daily dose)

INH	________	mg
Rifampin	________	mg
Rifabutin	________	mg
Rifamate® (INH+RIF)*	________	caps
Ethambutol*	________	mg
Pyrazinamide*	________	mg
Pyridoxine	________	mg
Other	________	

*Current CDC/ATS and Los Angeles County TB Control recommendations for treatment of uncomplicated TB for 2 months followed by INH &RIF for 4 months.

# 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)*:

Potential barriers to TB therapy adherence

☐ Mental Impairment
☐ Homeless
☐ Substance abuse
☐ Hx of any non-compliant behavior
☐ HIV

Is patient ambulatory:

☐ Yes — ☐ Self ☐ With Assist
☐ No

Tuberculosis Control Program use only:

Problems/Action: ______________________

Discharge Approved
☐ Yes ☐ No
___/___/___

Reviewed by: ______________________ Date reviewed: ___/___/___

Approved by: ______________________ Date approved: ___/___/___

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
2615 S. Grand Ave. Room 507
Phone: 213-745-0800 Fax: 213-749-0926

Hospital Discharge 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.

Discharge approval is valid for one working day from the "Date Approved". Any changes to the plan (i.e., change of discharge address, provider, medication regimen, infectious status) necessitates submission of a revised discharge care plan.

All AFB smear positive pulmonary TB suspects require a home evaluation, to determine if the environment is suitable for discharge. A Community Health Services (CHS) 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. Call the Tuberculosis Control Program prior to faxing documents to ensure timely processing.)