HOSPITAL DISCHARGE APPROVAL REQUEST FORM

SECTION A: Patient Contact Inform	ation		
Patient name:			DOB: / /
Tel. #: (1) ()	(2) ()		mm dd yyyy
	Apt.: Cir		tate: Zip:
Emergency contact name:	Relationship	o to patient:	_ Tel. #: ()
SECTION B: Discharge Information			
Discharging facility: Discharging facility tel. #: ()			
	Fl.: Cit		
Patient medical record #: Date of admission: / _ Planned discharged date: / Discharged to: Home (if not the same address as above, fill in address below)			
☐ Shelter ☐ Skilled nursing facility ☐ Jail/Prison ☐ Residential facility ☐ Other facility			
Name of facility:			Tel. #: ()
Address:	Apt./FI.:	City:	State: Zip:
Is patient scheduled to travel outside of N	YC? Yes No If yes, specify date/des	tination:	
SECTION C: Patient Follow-Up App	ointment		
Patient follow-up appointment date:	dd yyyy		
Physician assuming care:	dd yyyy Tel. #:	()	Cell. #: ()
Address:	City:	State	e: Zip:
Potential barriers to TB therapy adherence	e: None Adverse reactions Home	lessness	
☐ Physical disability (specify)		cify)	
Substance use (specify)	Mental disorder (special	fy)	Other
SECTION D: Laboratory Results			
Dates of three most recent acid fast bacilli (AFB) smears	Specimen source Acid fast bad		lli (AFB) smear results
/		☐ Positive Grad	le: Negative
/		☐ Positive Grad	le: Negative
/		☐ Positive Grad	le: Negative
SECTION E: Treatment Information			
Date TB therapy initiated:/ Interruption in therapy? Yes No If yes, state the reason and duration			
Date TB therapy initiated:/ Interruption in therapy? ☐ Yes ☐ No If yes, state the reason and duration of the interruption?			
·	☐ RIFmg ☐ PZAmg ☐ E	EMBmg □ SM	mg ☐ Vitamin B ₆ mg
at discharge: Injectables (specify) Other TB meds (specify)			
Frequency: Daily 2x weekly 3x weekly Other—			
Was a central line (i.e. PICC) inserted on the patient? ☐ Yes ☐ No			
Number of days of medications supplied t		Patient agree	d to be on DOT? Yes No
Print name of individual filling out this form:			mm dd yyyy
Name of responsible physician at the discharging facility:		License #:	
Signature of responsible physician at the discharging facility:		Tel. #: ()	
COMPLETED BY THE HEALTH DEPARTMENT BTBC NUMBER:			
Discharge approved: ☐ Yes ☐ No Action required before discharge:			
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Reviewed by:	NE LIEALTH OFFICER/DECIONES		Date: / /