



Public Health Division  
Communicable Disease

## TUBERCULOSIS (TB) DISCHARGE AUTHORIZATION REQUEST



**Public Health**  
Prevent. Promote. Protect.

**Santa Cruz County**

### - High Risk TB Suspects and Confirmed TB Cases-

- Please complete Part I and fax to the Santa Cruz County Communicable Disease Unit (CDU) prior to anticipated discharge date, (831) 454-5049.
- Note: the CDU office hours are Mon-Fri 8am-5pm, excluding weekends and holidays

<b>Part I: To be Completed by the Discharging Facility</b>			
Patient Name:		Date of Birth:	
Discharging Facility:		Anticipated Discharge Date:	
Discharge To: <input type="checkbox"/> Home <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Residential Facility <input type="checkbox"/> Shelter <input type="checkbox"/> Jail/Prison <input type="checkbox"/> Other _____			
Discharge Address:	City:	Zip Code:	Phone Number:
Active TB Diagnosis: <input type="checkbox"/> Suspected <input type="checkbox"/> Confirmed		Patient Still on Airborne Isolation?	
Site: <input type="checkbox"/> Pulmonary <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Part II: To be Completed by the Public Health Department</b>		
<input type="checkbox"/> Discharge Authorized <u>without</u> any Further Action		
<input type="checkbox"/> Discharge Authorized <u>when</u> the Following Actions are Completed:		
1. _____		
2. _____		
3. _____		
<input type="checkbox"/> Discharge <u>not</u> Authorized _____		
Santa Cruz County TB Controller:	Title: MD	
Signed For by:	Title: PHN	Date and Time:
Name ( <i>print</i> ) _____		
Signature _____		