## HOSPITAL DISCHARGE APPROVAL REQUEST FORM

Patient name:   BHAS WAT1   PAL	SECTION A: Patient Contact Information		
Tel. #: (1) (	Patient name: RHASWAT1 PAI		
Address: 35, C.R.PARK, PAC ROAD NATHONRY, SOBEPH. City: KOLKATA State: W.B. Zip; 70701/3  Emergency contact name: UTTAM KWMAR PAL Relationship to patient: HUSBAND Tel. 8: (	Tel. #: (1) ()	DOB: 10 / 03 / 1972	
Discharging facility: No Longun to Stace ive in PAHOW COTE  Address: 35, C.R. POTIX, P.K.C. Rured, Noutrepolity Ft. 35, City, Kolikatta State: V-B. Zip.: 70°01/3  Patient medical record 8:	Address: 35, C. R. PARK, PKC ROAD, NATAGARH, SODEPUR		
Discharging facility: No Longun to Stace ive in PAHOW COTE  Address: 35, C.R. POTIX, P.K.C. Rured, Noutrepolity Ft. 35, City, Kolikatta State: V-B. Zip.: 70°01/3  Patient medical record 8:	Emergency contact name: UTTAM KUMAR PAL. City: KULKATA State: WIB. Zip: 700113		
Discharging facility: No longular to Stackive in PAHEWH COVER.  Address: 35,c R POUX, PK.C. RUID, Notreputh FI: 35, City: KolkATA State: W.S. 7jp: 770113  Patient medical record s:	SECTION B: Discharge Information Relationship to patient: Tel. #: ()		
Patient medical record #: Date of admission:			
Discharged to: Other (if not the same address as above, if in address below)   Sheter   Skilled nursing facility   Jail/Prison   Residential facility   Other facility     Name of facility   Moti-Prison   Residential facility   Other facility     Name of facility   Moti-Prison   Residential facility   Other facility     Address: Loftic Motion Souton   Hother Souton	Address: 35, C. R. Povik, P.K. C. Ruzod, Natrocut College Discharging facility tel. #: ()		
Shelter   Skilled nursing facility   Jail/Prison   Residential facility   Other facility	City NOINTIN ON W.K - ANDITY		
Shetter   Shet		rianned discharged date:/ / mm dd yyyy	
Name of racity: Victorial victoriala	Shelter     Skilled purples to the	ility Other facility	
Patient follow-up appointment date: 6 12 1999 Physician assuming care: Dt. P.K. Bruwwick Tel. #: (	Address: Lotia Martin Salam Ida Pital	Tel. #: ()	
Patient follow-up appointment date: 6 12 1999 Physician assuming care: Dt. P.K. Bruwwick Tel. #: (	Is patient scheduled to travel outside of NVCD To The Apt./Fl.: City: Kon	State: V.B. Zip: 70006	
Patient follow-up appointment date: 6 / 12 / 1999 Physician assuming care: Dt. P. M. God Mills (Property Coll.) Physician assuming care: Dt. P. M. God Mills (Property Coll.) Physician assuming care: Dt. P. M. God Mills (Property Coll.) Physician assuming care: Dt. P. M. God Mills (Property Coll.) Address: SCLWOR Rured, State: D. B. Zip: T00110 Potential barriers to TB therapy adherence: Mone   Adverse reactions   Homelessness   Physicial disability (specify)   God Mills (Specify)   God Mills (Specify)   Gubstance use (specify)   Medical condition (specify)   Gother   SECTION D: Laboratory Results Dates of three most recent acid fast bacilli (AFB) smears  Dates of three most recent acid fast bacilli (AFB) smears  Specimen source   Acid fast bacilli (AFB) smear results    Positive Grade:   Negative	y = y = y = y = y = y = y = y = y = y =		
Action assuming care: UN-P.N. BANDWINCK Tel. #: Cell. #: (P) 94-73605618  Address: SQUADA RURAD, StrdepWit, City: Kulkadta State: W.B. Zip: T00110  Potential barriers to TB therapy adherence: None   Adverse reactions   Homelessness			
Address:CUBHNITER_SEGREPHY	Physician assuming care: Db P & Dt. 1737	91 047740543	
Potential barriers to TB therapy adherence: None   Adverse reactions   Homelessness     Physical disability (specify)	Address: School Road, Sodepwr,	Cell. #: (71) 94+ 1605618	
Physical disability (specify)     Medical condition (specify)   Other	Potential barriers to TB therapy adherence: None Adverse reactions Homelessness	State: Zip: Zip:	
Substance use (specify)   Other			
Dates of three most recent acid fast bacilli (AFB) smears			
Acid fast bacilli (AFB) smears   Specimen source   Acid fast bacilli (AFB) smear results	SECTION D: Laboratory Results		
Positive Grade:   Negative   Ne		Acid fast bacilli (AFB) smear results	
Positive Grade:   Negative   Negative   Positive Grade:   Negative   Negati		Positive Grade: Negative	
Date TB therapy initiated:		Positive Grade: Negative	
Date TB therapy initiated:		☐ Positive Grade: ☐ Negative	
of the interruption?  TB medications   INH   mg   RIF   mg   PZA   mg   EMB   mg   SM   mg   Vitamin B6   mg at discharge:   Injectables (specify)   Other TB meds (specify)    Frequency:   Daily   2x weekly   2x weekly   Other    Was a central line (i.e. PICC) inserted on the patient?   Yes   No  Number of days of medications supplied to patient at discharge   Patient agreed to be on DOT?   Yes   No  Print name of individual filling out this form:   BIASWAT   PAL   Date:   15	SECTION E: Treatment Information		
of the interruption?  TB medications at discharge:   Injectables (specify)   Other TB meds (specify)    Frequency:   Daily   2x weekly   2x weekly   Other    Was a central line (i.e. PICC) inserted on the patient?   Yes   No  Number of days of medications supplied to patient at discharge   Patient agreed to be on DOT?   Yes   No  Print name of individual filling out this form:   BHASWAT   PAL   Date:   15	Date TB therapy initiated: / / Interruption in therapy?  Yes  No If yes, state the reason and duration		
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 to patient at discharge   Patient agreed to be on DOT?   Yes   No  Print name of individual filling out this form:   BHASWAT   PAL   Date:   15			
Injectables (specify)			
Was a central line (i.e. PICC) inserted on the patient?     Yes   No	☐ Injectables (specify) ☐ ☐ Other 18 meds (specify) ☐		
Number of days of medications supplied to patient at discharge			
Print name of individual filling out this form:    BHASWAT PAL   Date: 15 / 12 / 1999			
Print name of individual filling out this form:  Name of responsible physician at the discharging facility:  Signature of responsible physician at the discharging facility:  COMPLETED BY THE HEALTH DEPARTMENT  Discharge approved:  No Action required before discharge:  Signature of responsible physician at the discharging facility:  Discharge approved:  Discharge approved:  Date:  Date	Training of days of modelating department of the second of		
Signature of responsible physician at the discharging facility:    Tel. #: ()   COMPLETED BY THE HEALTH DEPARTMENT   BTBC NUMBER:   Discharge approved:   Yes   No   Action required before discharge:   Reviewed by:   Date:   12   1999	Print name of individual filling out this form:	Date: 15 / 12 / 1779	
COMPLETED BY THE HEALTH DEPARTMENT  Discharge approved:   No Action required before discharge:  S. K. Dubta  Date: 15, 12, 1999	Name of responsible physician at the discharging facility:		
Discharge approved: Yes No Action required before discharge:  S. K. Dubto  Date: 15, 12, 1999	Signature of responsible physician at the discharging facility:	Tel. #: ()	
Discharge approved: Yes No Action required before discharge:  S. K. Dubto  Date: 15, 12, 1999	COMPLETED BY THE HEALTH DEPARTMENT	BTBC NUMBER:	
S. K. Dubta Date: 15, 12, 1999			
Reviewed by:	S.K. Duba	Date: 15, 12, 1999	
NAME OF HEALTH OFFICER/DESIGNEE	NAME OF HEALTH OFFICER/DESIGNEE	mm dd yyyy	