# HOSPITAL DISCHARGE APPROVAL REQUEST FORM

## SECTION A: Patient Contact Information

Patient name: BHASWATI PAL DOB: 10 / 03 / 1972 (mm / dd / yyyy)

Tel. #: (1) (____)____ ____ (2) (____)____ ____

Address: 35, C.R.PARK, PKC ROAD, NATAGARH, SODEPUR Apt.: ____ City: KOLKATA State: W.B. Zip: 700113

Emergency contact name: UTTAM KUMAR PAL Relationship to patient: HUSBAND Tel. #: (____)____ ____

## SECTION B: Discharging Information

Discharging facility: No longer to receive inpatient care Discharging facility tel. #: (____)____ ____

Address: 35, C.R.Park, P.K.C.Road, Natagarh Fl.: 35, City: KOLKATA State: W.B. Zip: 700113

Patient medical record #: ____ Date of admission: ____ / ____ / ____ (mm / dd / yyyy) Planned discharged date: ____ / ____ / ____ (mm / dd / yyyy)

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: Maternity ward

Address: Lohia Matri Sadan Hospital Apt./Fl.: ____ City: Kolkata State: W.B. Zip: 700006 Tel. #: (____)____ ____

Is patient scheduled to travel outside of NYC? ☐ Yes ☑ No If yes, specify date/destination: ____

## SECTION C: Patient Follow-Up Appointment

Patient follow-up appointment date: 6 / 12 / 1999 (mm / dd / yyyy)

Physician assuming care: Dr. P.K. Bhowmick Tel. #: (____)____ ____ Cell. #: (91) 9477605618

Address: School Road, Sodepur City: Kolkata State: W.B. Zip: 700110

Potential barriers to TB therapy adherence: ☑ None ☐ Adverse reactions ☐ Homelessness

☐ Physical disability (*specify*) ____ ☐ Medical condition (*specify*) ____

☐ Substance use (*specify*) ____ ☐ Mental disorder (*specify*) ____ ☐ Other ____

## SECTION D: Laboratory Results

| Dates of three most recent acid fast bacilli (AFB) smears | Specimen source | Acid fast bacilli (AFB) smear results |
|---|---|---|
| ____/____/____ | ____ | ☐ Positive Grade: ____ ☐ Negative |
| ____/____/____ | ____ | ☐ Positive Grade: ____ ☐ Negative |
| ____/____/____ | ____ | ☐ Positive Grade: ____ ☐ Negative |

## SECTION E: Treatment Information

Date TB therapy initiated: ____ / ____ / ____ (mm / dd / yyyy) Interruption in therapy? ☐ Yes ☐ No If yes, state the reason and duration of the interruption? ____

TB medications at discharge: ☐ INH ____ mg ☐ RIF ____ mg ☐ PZA ____ mg ☐ EMB ____ mg ☐ SM ____ mg ☐ Vitamin $B_6$ ____ mg

☐ 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 / 12 / 1999 (mm / dd / yyyy)

Name of responsible physician at the discharging facility: P.K. Bhowmick 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: ____

Reviewed by: S. K. Dutta (NAME OF HEALTH OFFICER/DESIGNEE) Date: 15 / 12 / 1999 (mm / dd / yyyy)