TEXAS Health and Human Services | Texas Department of State Health Services

Texas Center for Infectious Disease

Pre-Admission Clinical Worksheet

210-531-4508 fax

Date: _____

PART I: Patient Information

Last Name:_____First Name:_____MI: _____

Gender:_____ __DOB:_____Age:_____SSN: _____

Address:_____City:_____County:_____Zip: _____
Homeless _____ Phone _____

Race:_____Ethnicity:_____Language: _____

Place of Birth _____ Citizenship _____Country of Origin _____

Marital Status _____Employee Status _____ Religion _____

Guardianship _____Advanced Directive _Yes No Interested DNR/DNI
Power of Attorney _____

Court Order: ☐ Yes ☐ No Allergies: _____

Insurance: ☐ Medicare ☐ Medicaid ☐ Third Party ☐ Uninsured
Insurance Number _____
Emergency Contact / Next of Kin:
Last Name:_____First Name:_____MI: _____

Address:_____City:_____State:_____Zip: _____

Phone Number:_____Relationship: _____

PART II: Referring Provider

REFERRAL FROM REGION _____Local Health Department _____

Transfer from Name of Hospital _____

Physician Name:_____Referring Agency: _____

Case Manager:_____Phone: _____

Fax Number:_____Email: _____

PART III: Tuberculosis

Indication for Admission: _____

At least one of the below required:

Sputum / AFB Culture: ☐ Positive ☐ Negative ☐ Pending Date: _____

NAAT: ☐ Positive ☐ Negative ☐ Pending Date: _____

PCR: ☐ Positive ☐ Negative ☐ Pending Date: _____

Imaging:

Exam/Procedure:_____ Results:_____

Facility:_____ Address:_____ Phone:_____

Exam/Procedure:_____ Results:_____

Facility:_____ Address:_____ Phone:_____

Exam/Procedure:_____ Results:_____

Facility:_____ Address:_____ Phone:_____

Please send all imaging electronically in DICOM format to GRTCIDRadiology@dshs.texas.gov

Or by CD to 2303 Southeast Military Drive, SA,Tx 78223, ATT:Radiology Department Building 533

CD with Radiographs included: ◯ Yes ◯ No

Additional Tests:

Sputum / AFB Smear: ☐ Positive ☐ Negative ☐ Pending Date: _____

PPD: ☐ Positive ☐ Negative ☐ Pending Date: _____

IGRA: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending Date: _____

Tuberculosis Treatment:

Drug Susceptibilities: _____

Current Medications: _____

Date started: _____

Refused TB Medication Doses: ☐ Yes ☐ No # Missed Doses: _____

Previous Treatment: _____

Dates: _____

Adverse Reactions to TB Treatment: _____

Dates: _____

Family / Close Contacts with Current or Previous TB Treatment: _____

PART IV: Other Conditions

HIV: ☐ Positive ☐ Negative ☐ Pending Date: _____

Viral Load: _____ Date: _____

CD4: _____ Date: _____

Medical/Surgical History (check all that apply):

☐	Diabetes	☐	Drug Use	☐	Asthma
☐	GI Bleed	☐	High cholesterol	☐	Epilepsy/ Seizures
☐	Dialysis	☐	Hypothyroidism	☐	Anemia
☐	Oxygen	☐	Cancer	☐	HIV
☐	High blood pressure	☐	Meningitis	☐	Colitis
☐	Pneumothorax	☐	Kidney Disease	☐	Crohn's Disease
☐	Cirrhosis	☐	Depression	☐	Heart Disease
☐	Stroke	☐	Tobacco Use	☐	Psychiatric History
☐		☐		☐	Alcohol Use

Other: _____

Wounds / Drains: ☐ Yes ☐ No

Explain: _____

Functional Capacity: ☐ Independent ☐ Assisted ☐ Complete Care ☐ Total Care

Verbally / Physically Aggressive or Violent: ☐ Yes ☐ No

Explain: _____

Assistive Devices: ☐ Wheelchair ☐ Cane ☐ Walker ☐ Hearing Aids ☐ Glasses/Contacts

Diet: ☐ Regular Texture ☐ Modified Texture ☐ Tube Feeding ☐ TPN

Social Situation: ☐ Homeless ☐ Small Children ☐ Working ☐ US Citizen ☐ Documented

Advanced Directives: ☐ DNR ☐ DNI ☐ MPOA ☐ Other: _____

PART V: Records Included

☐	Diabetes	☐	Progress Notes
☐	Sputum Culture Results	☐	Discharge Summary
☐	TB Lab Results	☐	Consult Reports
☐	CXR / Chest CT Results	☐	Current Medication List
☐	Drug Susceptibilities	☐	DOT Records
☐	Other Imaging	☐	History and Physical

PART VI: Additional Information

_____

_____

_____

_____

==========

*** For TCID use only ***

Admission Approved ☐ Yes ☐ No (Specify reason):_____

Doctor Reviewing: _____ Date: _____

Doctor Signature: _____

Room Assigned: _____ by: _____

Attending Physician Assigned: _____

Airborne Isolation Required: ☐ Yes ☐ No

Expected Admission Date:_____Time: _____

Transport: ☐ Personal Vehicle ☐ Health Department ☐ Ambulance

Case Manager Comments: _____

_____

_____

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

JOHN HELLERSTEDT, M.D .
COMMISSIONER

Texas Center for Infectious Disease
•Jessica Gutierrez-Rodriguez, MSMOT Hospital Director
2303 S.E. Military Dr. • San Antonio, Texas 78223
210-534-8857 • http://www.dshs.state.tx.us

TCID Coronavirus Admission Screening Tool

Date: _____

Patient name: _____
City / County:_____

Screening Questions:

1.) Have you traveled to New York, Louisiana, China, South Korea, Japan, Italy, or Iran, in the last 30 days?

NO YES If yes when: _____

2.) Have you been in contact with someone who has traveled to the above countries in the last 30 days?

NO YES If yes, When? _____

3.) Have you been in contact with someone who has traveled to the above countries in the last 30 days who is now ill or anyone who tested positive for COVID-19 in the past 30 days?

NO YES If yes, When? _____

4.) Date of latest COVID-19 test (must be within 5 days of transfer to TCID): _____

***IF YES TO EITHER, NOTIFY MEDICAL STAFF AND LOCAL/STATE HEALTH DEPARTMENT.**

NOT A PART OF THE PERMANENT MEDICAL RECORD