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

Texas Center for Infectious Disease

Pre-Admission Clinical Worksheet

Date: _____

PART I: Patient Information

Last Name: _____ First Name: _____ MI: _____

Gender: _____ DOB: _____ Age: _____ SSN: _____

Address: _____ City: _____ County: _____ Zip: _____

Race: _____ Ethnicity: _____ Language: _____

Court Order: ☐ Yes ☐ No Allergies: _____

Insurance: ☐ Medicare ☐ Medicaid ☐ Third Party ☐ Uninsured

Emergency Contact / Next of Kin:

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Relationship: _____

PART II: Referring Provider

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:

CXR Results: _____ Date: _____

Chest CT Results: _____ Date: _____

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

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

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

PART VI: Additional Information

_____

_____

_____

_____

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*** 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: _____

_____

_____