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

TEXAS CENTER FOR INFECTIOUS DISEASE
2303 S.E. Military Drive
San Antonio, Texas 78223
210-534-8857

PRE-ADMISSION CLINICAL WORKSHEET

Thank you for your referral to our facility. In order to make sure we can meet the needs of the patient we need specific information included along with the completed Pre-Admission Worksheet.
If the patient is in a hospital or inpatient facility we need: Admission H&P, current MAR, most recent labs, most recent progress notes, most recent consults (PT/OT/Dietary, etc.) and any radiology imaging reports.
If the patient is at home we need: Current and prior regimens, most recent labs, DOT records, TB400A and TB400B, and radiology imaging reports.

Fax Information to: 210-531-4508

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: ______________________

Insurance: ☐ Medicare ☐ Medicaid ☐ Third Party ☐ Uninsured

Policy 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/County: _______________________

Local Health Department Contact Name (**REQUIRED**): ____

Transfer from Name of Hospital: ____

Physician Name: ______________________________ Referring Agency: ______________________________

Case Manager: _______________________________ Phone: _____________________________________

Fax Number: _________________________________ Email: _____________________________________

PART III: Tuberculosis Diagnosis

Indication for Admission: ____

*At least one of the below required (**PLEASE INCLUDE REPORT**):*

☐ Sputum / AFB Culture

☐ NAAT

☐ PCR

☐ Drug Susceptibilities

☐ MDDR

PART IV: Tuberculosis Treatment

Current Tuberculosis Medications:

Medication	Dose	Frequency	Date Started

Refused TB Medication Doses: ☐ Yes ☐ No   # of Missed Doses: _____________

Previous Treatment: ____

Dates: ____

Adverse Reactions to TB Treatment: ____

Dates: ____

Family / Close Contacts with Current or Previous TB Treatment:

PART V: High Consequence Infectious Disease

Symptom checklist: ☐ Vomiting ☐ Diarrhea ☐ Rash ☐ Fever

Recent travel to include International: ☐ Yes ☐ No

Is the patient part of an epidemiologically linked group of patients presenting with severe acute respiratory illness or unknown etiology or does the provider have any suspicion for High-consequence infectious disease in addition to tuberculosis?

☐ Yes ☐ No

If yes, Explain:

____

PART VI: Other Conditions

HIV: ☐ Positive ☐ Negative (**Include report with Viral Load and CD4 Count and Genotype**)

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
☐	Hepatitis	☐	COVID Infection	☐	Alcohol Use

Other: ____

Skin Assessment: Rash / Wounds / Drains: ☐ Yes ☐ No

Explain: ____

Height: ____________ Weight: ____________

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: ____________________

Guardianship: ____

PART VII: Records Included

☐	Diabetes	☐	Other Imaging Reports	☐	Drug Susceptibilities
☐	Sputum Culture Results	☐	Discharge Summary	☐	DOT Records
☐	TB Lab Results	☐	Consult Reports	☐	Progress Notes
☐	CXR (Chest X-ray) Reports	☐	Current Medication List	☐	History and Physical

PART VIII: Additional Information

Most Recent Radiology Contact Information: Radiologist Provider:____

Phone Number: ____________Fax Number: _____________ Email: ____

Any Additional Information: