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

Texas Center for Infectious Disease

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 imaging reports.
If the patient is at home we need: Current and prior regimens, most recent labs, DOT records, TB400A and TB400B, and 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

If available, send CD with Radiographs:
Texas Center for Infectious Disease
ATTN: Outpatient Clinic
2303 SE Military Drive
San Antonio, TX 78223

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: 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: _____

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: _____

Guardianship: _____

PART VI: Records Included

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

PART VII: Additional Information