

Request for Reimbursement of Civil Detention of a Persistently Non-Adherent Tuberculosis Patient

Prior to a detention or within 5 working days after detention start date, complete this form and fax to: TB Control Branch (TBCB) Civil Detention Coordinator, (510) 620-3031. *Reimbursement for detention will not occur until this form has been submitted to, and approved by, the TBCB. Instructions for completing this form are provided on the next page.*

RVCT OR SUSPECT ID NUMBER OF PATIENT _____

Patient's Initials: First ____ Last ____

Patient's Date of Birth ____/____/____

Requesting Health Jurisdiction _____

Date of Request _____

Detention Site _____

First day of detention _____

Contact Name _____

Telephone Number (____) _____

Does the patient have insurance coverage for any part of his or her care? Yes No

If Yes, specify type: _____

To be completed by Local Health Jurisdiction

Signature of Person Ordering Detention _____ Date _____

Print Name _____ Title _____

Telephone (____) _____ Fax number for return of form (____) _____

Detention Plan Submitted to TBCB? YES ____ NO ____ UNKNOWN ____

Part I. Required Documentation

Please attach the following:

- 1) Individualized Assessment*(CDHS CTCA Joint Guidelines define as patient history, treatment history); 2) DOT history; 3) Less restrictive alternatives attempted or less restrictive alternatives considered and rejected and reason for rejection*; 4) Copies of diagnostic tests used to determine TB; and 5) Copy of order of detention and any other order issued to patient by local health officer.

*Required by Health and Safety Code (H&S Code) §121367.

PART II. Reason for Detention (check one only)

Detention for Isolation (H&S Code, Section 121365(d))

Detention for Completion of Treatment (COT) (H&S Code, Section 121365(e))

Check all that apply:

<input type="checkbox"/>	Leaving hospital against medical advice while infectious	<input type="checkbox"/>	Missing clinic/physician appointments Number ____
<input type="checkbox"/>	Receiving visitors while infectious	<input type="checkbox"/>	Failing to refill medication orders or pick up prescriptions
<input type="checkbox"/>	Returning to work while infectious	<input type="checkbox"/>	Refusing to mask or cover cough when instructed to do so
<input type="checkbox"/>	Leaving home while infectious	<input type="checkbox"/>	Moving without notifying health department
<input type="checkbox"/>	Refusing or leaving hospital respiratory isolation	<input type="checkbox"/>	Violation of Order for COT - H&S 121365(b)
<input type="checkbox"/>	Refusing to submit sputum specimens for determination of infectiousness	<input type="checkbox"/>	Violation of Order for DOT - H&S 121365(c)
<input type="checkbox"/>	Leaving hospital against medical advice	<input type="checkbox"/>	Violation of Order of Exclusion - H&S 121365 (f)
<input type="checkbox"/>	Refusing to take medication	<input type="checkbox"/>	Violation of Order of Isolation - H&S 121365 (g)
<input type="checkbox"/>	Missing treatment doses # ____ Over ____ Wks.	<input type="checkbox"/>	Other, specify

Comments: (Attach additional pages as necessary)

Approval for Reimbursement (for TBCB use only)

This request for reimbursement is ____ approved ____ denied

If denied, reason(s) _____

Signed _____ Date _____

Jan Young, RN, M.S.N., Chief, TBCB Program Development Section