Sonoma County TUBERCULOSIS TRANSFER/DISCHARGE PLAN (GOTCH Form)

Health and Safety Code §121362 states that all health facilities shall not discharge, transfer, or release a patient until notification and a written plan has been submitted and approved by the Local Health Officer for all people known or suspected to have active tuberculosis. This plan must be approved before the patient can be discharged.

To: TB Control Officer Sonoma County Phone: (707) 565-4568 FAX: (707) 565-4565	☐ **INITIAL REPORT** ☐ **READMISSION** ☐ **TRANSFER** ☐ **DISCHARGE**	FROM:

PATIENT INFORMATION

PATIENT INFORMATION	Race/Ethnicity/Language:		
Name (last, first, middle):	AKA:		
Address Prior to Admission:	Age:	DOB:	Occupation:
Address After Discharge/Transfer:	Phone:		
Legal Guardian/Next of Kin:	Phone:		
Parole Officer:	Phone:	Booking #:	

HOSPITALIZATION INFORMATION

HOSPITALIZATION INFORMATION Name of Institution	Date of Admission:
Hospital Physician's Name and Phone #:	

PATIENT TB INFORMATION

Status:
- ☐ Suspected TB
- ☐ Verified
- ☐ Immunosuppressed

Site:
- ☐ Pulmonary
- ☐ Laryngeal
- ☐ Extrapulmonary Site:

Date (mm/dd/yy)	AFB Source/Site	AFB Smear Results	NAAT/PCR Results	AFB Culture Results	Organism Identified

Medication	Dosage/Frequency	Date Started	Date Stopped		
				Initial Chest X-Ray (CXR) Date:	Results: ☐ Cavitary ☐ Noncavitary ☐ Normal
INH				Most Recent Follow-up CXR Date:	Results: ☐ Improved ☐ Stable ☐ Worse ☐ Not done
RIF				Most Recent TST/IGRA Date:	☐ Mantoux __________ (mm induration) ☐ IGRA ☐ Negative ☐ Positive
EMB				Weight (kg): Date:	Household: Number of Adults = Number of Children = ☐ Newborn/Child under 1 year ☐ Immunocompromised:________________
PZA				**DISCHARGE PLANNING** Anticipated Discharge Date: Number of days of medication provided to patient upon discharge:	
Other Specify:				Discharge To: ☐ Home ☐ Skilled Nursing Facility ☐ Shelter ☐ Homeless ☐ Jail/Prison ☐ Other (specify):	

Primary Medical Provider: Phone:	Medical Provider for **Tuberculosis Treatment After Discharge**: Phone: Follow-up Appointment Date and Time: ______________ @ _________ AM/PM
Completed By:	Phone: Fax: Date:

Discharge Approved: ☐ Yes ☐ No. If denied, see below for action required.

HEALTH OFFICER/TB CONTROLLER RESPONSE

_____________________________ Signature

_______________ Date

Please attach labs and imaging to GOTCH and send via fax, (707) 565-4565, or email, PHnurse@sonoma-county.org. GOTCH assessed during business hours only.

03-2023