SANTA CLARA COUNTY TUBERCULOSIS REPORT/ READMISSION/TRANSFER/DISCHARGE PLAN (GOTCH Form)

To: TB Control Officer Santa Clara County Phone: (408) 885-2440 FAX: (408) 885-2331	☐ **INITIAL REPORT** ☐ **READMISSION** ☐ **TRANSFER** ☐ **DISCHARGE**	FROM:

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

PATIENT TB INFORMATION

Status:
☐ Suspect
☐ 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:	
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:	
Completed By:				Follow-up Appointment Date and Time: _____ @ _____ AM/PM Phone: Fax: Date:	

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

HEALTH OFFICER/TB CONTROLLER RESPONSE

_____ _____
Signature Date