HEALTH SERVICES AGENCY
Public Health Services
Tuberculosis Control
820 Scenic Drive
Modesto, CA 95350
Phone: 209-558-8880
Fax: 209-558-7531
www.hsahealth.org

TB "GOTCH" DISCHARGE PLAN OF CARE

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. In order to carry out the department's legal responsibility under the Health and Safety Code §121362, we are requesting this form be completed and submitted to Public Health Services **48 hours prior** to discharge. This plan must be approved before the patient can be discharged. We appreciate your cooperation.

NAME: _____ DOB: _____ SSN: _____ MRN: _____

ADMIT DATE: _____ DISCHARGE DATE: _____ PHYSICIAN: _____

FACILITY: _____ PHONE: _____ CONTACT PERSON: _____

DIAGNOSIS: ☐ TB Confirmed ☐ TB Suspect SITE: ☐ Pulmonary ☐ Laryngeal ☐ Extrapulmonary _____

PPD: Date Administered: _____ Results: _____mm ☐ Positive ☐ Negative ☐ Hx of Positive ☐ Not done

QFT: Date collected: _____ Results: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Hx of Positive ☐ Not done

CXR: Date: _____ ☐ Cavitary ☐ Noncavitary ☐ Normal ☐ Other: _____

LAB RESULTS

HIV: Date collected: _____ Results: ☐ Positive ☐ Negative ☐ Hx of Positive

Specimen #1 Date: _____ Type: ☐ Sputum ☐ Other: _____ AFB Smear: ☐ Positive ☐ Negative ☐ Pending ☐ Not Done

NAAT/PCR: ☐ Positive ☐ Negative ☐ Pending ☐ Not Done AFB Culture: ☐ Positive ☐ Negative ☐ Pending ☐ Not Done

Specimen #2 Date: _____ Type: ☐ Sputum ☐ Other: _____ AFB Smear: ☐ Positive ☐ Negative ☐ Pending ☐ Not Done

NAAT/PCR: ☐ Positive ☐ Negative ☐ Pending ☐ Not Done AFB Culture: ☐ Positive ☐ Negative ☐ Pending ☐ Not Done

Specimen #3 Date: _____ Type: ☐ Sputum ☐ Other: _____ AFB Smear: ☐ Positive ☐ Negative ☐ Pending ☐ Not Done

NAAT/PCR: ☐ Positive ☐ Negative ☐ Pending ☐ Not Done AFB Culture: ☐ Positive ☐ Negative ☐ Pending ☐ Not Done

TREATMENT Patient's Weight: _____ lbs_____oz

Medication	Dose	Date Started	Date Stopped	Reason Stopped
1. Isoniazid (INH)	_____mg	_____	_____	_____
2. Rifampin (RIF)	_____mg	_____	_____	_____
3. Pyrazinamide (PZA)	_____mg	_____	_____	_____
4. Ethambutol (EMB)	_____mg	_____	_____	_____
5. Pyridoxine (B-6)	_____mg	_____	_____	_____

MEDICATIONS **WILL BE PROVIDED** TO PATIENT UPON DISCHARGE: ☐ Yes ☐ No Number of Days_____

HOME ISOLATION PROCEDURES EXPLAINED AND MASKS PROVIDED TO PATIENT: ☐ Yes ☐ No ☐ N/A

PHYSICIAN TO FOLLOW TB CARE: _____

PHYSICIAN TO FOLLOW PRIMARY CARE: _____

DISCHARGE TO: ☐ HOME ☐ APARTMENT ☐ BOARD & CARE ☐ SKILLED NURSING

OTHER_____

DISCHARGE ADDRESS_____ PHONE: _____

NAME OF PERSON COMPLETING / TITLE_____PHONE: _____

PLEASE FAX TO PUBLIC HEALTH SERVICES (209) 558-7531

HEALTH DEPARTMENT REVIEW

☐ DISCHARGE ☐ APPROVED ☐ DENIED DATE: _____ BY: _____

ACTION TO BE TAKEN: _____

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