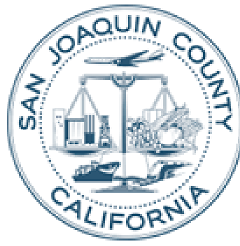
San Joaquin County

Department of Public Health



Tuberculosis Control Section

Maggie Park., MD, Health Officer
Cristina Almeida., MD, Assistant Health Officer

Discharge Checklist for Tuberculosis "Gotch" Plan of Care

Tel: (209) 468-3828 **Fax:** (209) 468-8222

Patients with active or suspected tuberculosis may only be discharged after DPH review and signed approval on Section E of this form
Please submit ALL of the following 24 hours prior to anticipated discharge (48 hours for non-San Joaquin Residents)

- ❑ Hospital Discharge Approval Forms packet faxed to TB Control:
  - Completed Tuberculosis Discharge Approval Form
  - Discharge Checklist (this document)

- ❑ Medical records faxed to TB Control:
  - Physician notes (H&P, Progress notes, Pulmonary/ID Consult notes, Other Consult notes, D/C summary)
  - Medication list & dosages (including non-TB medications)
  - Daily MAR of TB meds (to confirm daily observed therapy)
  - Diagnostic tests (AFB smear/culture, molecular tests, pathology)
  - Radiology reports (CXR, CT)
  - Lab Results (QFT, CBC, CMP, hepatitis serologies, HgbA1c or fasting glucose, CRP, urine pregnancy test if patient is of childbearing age)

- ❑ Required labs to be done prior to discharge (QFT, CBC, CMP, hepatitis, HgbA1c or fasting glucose, CRP, urine pregnancy test if patient is of childbearing age).

- ❑ Patient is scheduled for a follow-up appointment with Infectious Disease or Pulmonary Medicine within 2-3 weeks from hospital discharged.

- ❑ A 30-day of ALL TB medications on hand (verified by staff nurse).

- ❑ Discharges will not be approved on weekends/holidays.

- ❑ TB Control Business Hours are Monday to Friday, 8:00 AM to 5:00 PM.

You will receive confirmation by call/fax within 24-48 hours of submitting the discharge "Gotch" Plan of Care form information. If you have any questions regarding TB hospital discharge procedures, please contact the San Joaquin county Tuberculosis Control Program at phone number (209) 468-3828.

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Tuberculosis "Gotch" Plan of Care Discharge Approval Form

MANDATORY REPORTING: Per State of California Health and Safety Code Sections 121361(a)(1) and 121362, 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/TB Controller for all people known or suspected to have active tuberculosis. This form must be completed to carry out the department's legal obligation. **Please contact the TB Control Office at least 24 hours prior to the anticipated discharge time, or 48 hours if patient is a non-San Joaquin resident.**

Section A: Patient Information

Name: ______________________________ Alias (if any): _______________ Gender: ❑ M ❑ F ❑ Other: _______________

Address: ____

Date of Birth: _____/_____/______ Phone: (____) ________________ Primary Language: ______________________________

Race/Ethnicity: ________________ Country of Origin: ___________________ Date Arrived (in the US): _____/_____/______

Occupation: ___________________ Medical Insurance: __________________________ Last 4 digits of SSN: ________

Emergency Contact: ____ Phone: (____) __________________________________

Section B: Hospital Information

Date of Admission: _____/_____/______ Medical Record Number.: ____________________________________

Institution/Hospital: ___________________________ Resident/Attending: ____

Room/Location: _______________________________ Provider Contact: (____) ____________________________ (pager/cell)

Section C: Patient TB Information

Status: ❑ Lab Confirmed ❑ Suspected Date of TB Diagnosis: _____/_____/______ Symptom Onset: _____/_____/______

Date Reported to Health Department/TB Control: _____/_____/______

Immunocompromised: ❑ Yes ❑ No Psychiatric Evaluation: ❑ Yes ❑ No

Substance Use Disorder: ❑ Yes ❑ No Psychiatric Disability: ❑ Yes ❑ No

Unhoused/Marginally Housed: ❑ Yes ❑ No Cognitive Deficit: ❑ Yes ❑ No

Test	Date		Result	
Current: ❑ PPD/TST ❑ QFT/IGRA	_____/_____/______	_____/_____/______	❑ Pos_mm__ ❑ Neg	❑ Pos_ ❑ Neg
Initial CXR			Attach Report	
Most Recent CXR			Attach Report	

Current Symptoms: ❑ Cough ❑ Fever/Chills ❑ Weight loss ❑ Night sweats

Initial Bacteriology

Date Collected	Source/Site	AFB Smear Results	NAAT/PCR	AFB Culture Results
		❑ Pos ❑ Neg	❑ Pos ❑ Neg ❑ N/A	❑ Pos ❑ Neg ❑ Pend
		❑ Pos ❑ Neg	❑ Pos ❑ Neg ❑ N/A	❑ Pos ❑ Neg ❑ Pend
		❑ Pos ❑ Neg	❑ Pos ❑ Neg ❑ N/A	❑ Pos ❑ Neg ❑ Pend

Current Bacteriology

Date Collected	Source/Site	AFB Smear Results	NAAT/PCR	AFB Culture Results
		❑ Pos ❑ Neg	❑ Pos ❑ Neg ❑ N/A	❑ Pos ❑ Neg ❑ Pend
		❑ Pos ❑ Neg	❑ Pos ❑ Neg ❑ N/A	❑ Pos ❑ Neg ❑ Pend
		❑ Pos ❑ Neg	❑ Pos ❑ Neg ❑ N/A	❑ Pos ❑ Neg ❑ Pend

Section D: Discharge Information

Current TB Treatment Start Date: _____/_____/______

Site of Disease: ❑ Pulmonary ❑ Extrapulmonary (specify): ____________________

Medication	Dosage/Frequency	Medication	Dosage/Frequency
1.		6.	
2.		7.	
3.		8	
4.		9.	
5.		10.	
Test Date	**Result**	**Test Date**	**Result**
HIV:			

Patient's current standing weight: _____ lbs. Anticipated discharge date: _____/_____/______

Discharge to: ❑ Home ❑ Shelter* ❑ SNF* ❑ Jail/Prison ❑ Other (specify)* ______________________________

Please list address: ____

Referrals Prior to discharge: ❑ Home Health ❑ Hospice/Palliative Agency Name: ______________________________

Primary Medical Doctor (PMD): ______________________________ Follow-up appointment: _____/_____/______

Address/Institution: ____

Phone: (_____) ________________________ Fax: (_____) ____________________________

Infectious Disease Doctor (ID): ______________________________ Follow-up appointment: _____/_____/______

Address/Institution: ____

Phone: (_____) ________________________ Fax: (_____) ____________________________

***To whom should DPH return a copy of this form, "TB Discharge Approval Form," once Section E is completed?

Name: ____ Fax: (_____) __________________

Fax this form to # (209) 468-8222 DO NOT discharge patient until final approval from San Joaquin County Public Health.

Section E: FOR DPH USE ONLY

Public Health Home/Residence Evaluation

Household Composition: Type of Residence:___________________________________

Number of People in dwelling:________ Patient has own room?____ Yes / ____ No

Number of Children <6 yrs. old:_______ Immunocompromised household members?____ Yes / ____ No

Actions required prior to discharge:

____

____

Discharge:
- ☐ Approved after identified actions completed.
- ☐ Approved with no restrictions
- ☐ Not approved

Signature: ____ Date: _____/_____/______

Health Officer / TB controller