



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



To: TB Control Officer Tuolumne County Public Health Phone: (209) 533-7401 FAX: (209) 533-7439	<input type="checkbox"/> INITIAL REPORT <input type="checkbox"/> READMISSION <input type="checkbox"/> TRANSFER <input type="checkbox"/> DISCHARGE	FROM:
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PATIENT INFORMATION		Race/Ethnicity/Language:	
Name (last, first, middle):		AKA:	
Address Prior to Admission:		Age:	DOB:
Address After Discharge/Transfer:		Occupation:	
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:	Site:
				<input type="checkbox"/> Suspect	<input type="checkbox"/> Pulmonary
				<input type="checkbox"/> Verified	<input type="checkbox"/> Laryngeal
				<input type="checkbox"/> Immunosuppressed	<input type="checkbox"/> 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: <input type="checkbox"/> Cavitory <input type="checkbox"/> Noncavitory <input type="checkbox"/> Normal
INH				Most Recent Follow-up CXR Date:	Results: <input type="checkbox"/> Improved <input type="checkbox"/> Stable <input type="checkbox"/> Worse <input type="checkbox"/> Not done
RIF				Most Recent TST/IGRA Date:	<input type="checkbox"/> Mantoux _____ (mm induration) <input type="checkbox"/> IGRA <input type="checkbox"/> Negative <input type="checkbox"/> Positive
EMB				Weight (kg): Date:	Household: Number of Adults = Number of Children = <input type="checkbox"/> Newborn/Child under 1 year <input type="checkbox"/> Immunocompromised: _____

PZA	DISCHARGE PLANNING Anticipated Discharge Date:				
Other Specify:	Discharge To: <input type="checkbox"/> Home <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Shelter <input type="checkbox"/> Homeless <input type="checkbox"/> Jail/Prison <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No. If denied, see below for action required.	
HEALTH OFFICER/TB CONTROLLER RESPONSE	
_____ Signature	_____ Date