Santa Clara County
Tuberculosis GOTCH Approval Form

MANDATORY REPORTING: State of California Health and Safety Code Sections 121361(a)(1) and 121362

To: TB Control Officer Santa Clara County Phone: (408) 885-2440 Fax: (408) 885-2331 Email: PHTBProgram@phd.sccgov.org	☐ Initial Report ☐ Readmission ☐ Transfer ☐ Discharge ☐ UnGOTCH	From:

PATIENT INFORMATION

	Race/Ethnicity:	Preferred Language:
Name (Last, First, Middle):	MRN:	Gender:
Address Prior to Admission:	Age: DOB:	Occupation:
Address After Discharge/Transfer:	Patient Phone:	
Legal Guardian/Next of Kin:	Phone:	
Parole Officer: Phone:	Booking #:	
Hospital Physician's Name and Direct Phone #:	Date of Admission:	

PATIENT TB INFORMATION
(check all that apply)

Status: ☐ Suspect ☐ Verified ☐ Immunosuppressed

Site: ☐ Pulmonary ☐ Laryngeal ☐ Extrapulmonary Site(s):

Date (m/d/yyyy) (Initial or Most Current)	AFB Source/Site	AFB Smear Results	NAAT/PCR Results	AFB Culture Results	Organism Identified if Culture Positive (MTB, NTM)
		☐ Pos ☐ Neg	☐ Pos ☐ Neg ☐ Pend ☐ N/A	☐ Pos ☐ Neg ☐ Pend	
		☐ Pos ☐ Neg	☐ Pos ☐ Neg ☐ Pend ☐ N/A	☐ Pos ☐ Neg ☐ Pend	
		☐ Pos ☐ Neg	☐ Pos ☐ Neg ☐ Pend ☐ N/A	☐ Pos ☐ Neg ☐ Pend	
		☐ Pos ☐ Neg	☐ Pos ☐ Neg ☐ Pend ☐ N/A	☐ Pos ☐ Neg ☐ Pend	

Tuberculosis Medication	Dosage/ Frequency	Date Started During this Hospitalization	Date Stopped (Leave blank if N/A)
Isoniazid			
Rifampin			
Ethambutol			
Pyrazinamide			
Pyridoxine (Vitamin B6)			
Other (Specify)			

Initial Chest X-Ray (CXR) Date:	Results: ☐ Cavitary ☐ Noncavitary ☐ Normal
Most Recent Follow-up CXR Date:	Results: ☐ Improved ☐ Stable ☐ Worse ☐ Not Done
Most Recent TST or IGRA Date:	☐ TST ______ (mm induration) ☐ IGRA ☐ Negative ☐ Positive
Weight (kg):	Date:

Household (if known) Number of Adults: _____
Number of Children: _____ Infants under 1 yr: _____
Immunocompromised: __________________________

DISCHARGE PLANNING (Two days prior to discharge request)

Anticipated Discharge Date: _______________

Days of TB Medicine on Hand: ______ Days

Discharge To:
☐ Home ☐ Jail/Prison ☐ Skilled Nursing Facility
☐ Shelter ☐ Motel ☐ Other (specify):

Primary Medical Provider
Provider Name: ________________________________
Facility: ________________________________
Direct Phone #: ____________________________

Medical Provider for Tuberculosis Treatment
After Discharge: ____________________________
Direct Phone Number: ________________________________
TB Follow-up Appointment:
Date: ______________ **Time:** ____________ AM PM

Form Completed By: Date: Phone: Fax: Email:

HEALTH OFFICER/TB CONTROLLER RESPONSE

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

____________________________ Signature

____________________________ Date