Napa County Tuberculosis Report/ Transfer / Discharge Plan

(GOTCH FORM)

TO: TB Control Officer Napa County Phone: (707) 253-4231 Fax: (707) 299-4479	☐ **INITIAL REPORT** ☐ **TRANSFER** ☐ **DISCHARGE**	Completed by: Date: Phone: Fax:

PATIENT INFORMATION

Name (Last, First Middle):	Language:		Race/ Ethnicity:
Address Prior to Admission:	Age:	DOB:	Occupation:
Legal Guardian/ Next of Kin:	Phone:		

HOSPITALIZATION INFORMATION	Name of Institution:	Date of Admission:
Hospital Physician's Name: Phone No.:		

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
INH			
RIF			
EMB			
PZA			
Vit B6			
Other (Specify)			

Initial Chest X-Ray (CXR) Date:	Results: ☐ Cavitary ☐ Abnormal consistent with TB ☐ Noncavitary ☐ Abnormal non-consistent with TB ☐ Normal
Most recent F/U CXR Date:	Results: ☐ Improved ☐ Stable ☐ Worse ☐ Not done
Initial CT Scan Date:	Results: ☐ Cavitary ☐ Abnormal consistent with TB ☐ Noncavitary ☐ Abnormal non-consistent with TB ☐ Normal
TST/QFTG/ T-Spot. Date:	☐ Mantoux TST _____ (mm induration) ☐ QFTG ☐ Positive ☐ Indeterminate ☐ T-Spot ☐ Negative
Weight (kg) Date:	Household: Number of adults = ____ Number of children = ____ ☐ Newborn/ Child under 6 ☐ Immunocompromised:

DISCHARGE PLANNING

Discharge To: (Select Box Below) Anticipated Discharge Date:
☐ Home ☐ Skilled Nursing Facility
☐ Shelter ☐ Homeless
☐ Jail/ Prison ☐ Other (specify):

Number of days of medication supply:

Address: Phone:

Discharge Approved: ☐ **YES** ☐ **NO**
(If NO is checked, see the Health Officer/ TB Controller response below)

Medical provider for Tuberculosis treatment after discharge:
Medial Provider Name: _____
Phone: _____

HEATLH OFFICER/ TB CONTROLLER RESPONSE

Follow-up appointment date and time @ AM/PM

Signature Date