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DEPARTMENT OF HEALTH & SOCIAL SERVICES

SOLANO COUNTY

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DISCHARGE OF A SUSPECT OR CONFIRMED TUBERCULOSIS PATIENT
GOTCH Law for All Patients in Healthcare Facilities

In order to protect the Public Health, as of January 01, 1994, State Health and Safety Code Section 121361 mandates that patients suspect for or confirmed with TB may not be discharged or transferred without prior Solano County Health Officer/TB Controller approval.

All active or suspect TB patients being discharged from the hospital or transferred to another healthcare facility or congregate setting require prior approval by Solano County Health Officer/TB Controller. A Solano County Tuberculosis Report, Transfer and Discharge Plan (GOTCH Form) must be completed and approval obtained from the County Health Officer/TB Controller prior to discharge or transfer. **TB Control requires 2 work days to review and approve a GOTCH request**. Please submit an initial GOTCH as soon as a patient is considered a TB suspect or is confirmed to have TB. GOTCH forms are to be faxed to our confidential line: (707) 784-5927.

Please fill in the **Solano County Tuberculosis Report, Transfer and Discharge Plan (GOTCH Form)** form completely and provide the following supporting documentation to facilitate discharge:

- Physician notes (including Emergency Department notes & Infectious Disease Consult
- Medication list (including TB and non-TB medications)
- Radiology (Chest X-ray reports, CT reports), Pathology if available
- Three acid fast bacilli (AFB) sputum smears and cultures at least 8 hours apart, with at least one a.m. specimen
- One sputum MTB PCR by nucleic acid amplification testing (NAAT), which should be performed on the same specimens as AFB smears and culture.
- Interferon gamma release assay (IGRA)—either QuantiFERON or T-Spot

Solano County TB Control Staff will review the plan and inform the provider of additional information or action needed prior to approving discharge. Each request to discharge/transfer a patient will be evaluated on a case-by-case basis. The final determination will be made by the county TB Controller and additional documentation or information may be required before discharge is approved.

Solano County TB Control Staff will conduct a home assessment within 3 working days of notification to determine if the environment is suitable for discharge. Staff will also plan around patients who are homeless or if a concern for non-compliance exists.

HOLIDAY AND WEEKEND DISCHARGE

There are no provisions at this time for either HOLIDAY or WEEKEND discharge due to staffing limitations. If the discharge cannot be approved, the patient MUST be held until the next business day for appropriate arrangements to be made.

NOTE: Use of this form is for discharge planning only. To fulfill State requirements for disease reporting a TB-CMR Form must also be completed and submitted.

SOLANO COUNTY TUBERCULOSIS REPORT/TRANSFER/DISCHARGE PLAN (GOTCH FORM)

At least TWO WORKING DAYS prior to discharge please complete and fax to the TB Controller at (707)784-5927

To: Health Officer/ TB Controller **Solano County Public Health: TB Control Program** **275 Beck Avenue, MS 5-240** **Fairfield, CA 94533** **Phone: (707)784-8001** **Fax: (707)784-5927**	☐ **INITIAL REPORT** ☐ **TRANSFER REQUEST** ☐ **DISCHARGE REQUEST**	**From:**

PATIENT INFORMATION

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

HOSPITALIZATION INFORMATION

Name of Institution:

Date of Admission:

PATIENT TB INFORMATION

Status: ☐Suspect ☐Verified Case (*If verified case, please report via CMR)

TB Site: ☐ Pulmonary ☐ Laryngeal ☐ Extrapulmonary Site:

Date:	AFB Source/Site	AFB Smear Result	NAAT/PCR Result	AFB Culture Result	Organism Identified

Initial Chest X-Ray (CXR)
Date:

Result:
- ☐ Cavitary
- ☐ Non-cavitary
- ☐ Normal

Most Recent Follow-Up CXR
Date:

Result:
- ☐ Improved
- ☐ Stable
- ☐ Worsened
- ☐ Not Done

Most Recent TST/IGRA
Date:

- ☐ Mantoux _____mm induration
- ☐ IGRA negative
- ☐ IGRA positive

Patient's TB Risk Factors
☐ Diabetes ☐ Renal Disease ☐ Organ Transplant Hx ☐ Homeless
☐ Substance Abuse Hx ☐ Alcohol Abuse ☐ Smoker ☐ Gastrectomy Hx
☐ Immunosuppressant Treatment ☐ Previous Contact to Active TB Case
☐ **History of TB Treatment**
Date: Tx Regimen:
☐ **History of Latent TB Treatment**
Date: Tx Regimen:
Country of Origin: U.S. Arrival Date:

Current TB Symptoms:
☐Cough ☐Sputum ☐Chest Pain ☐Fever ☐Fatigue ☐Anorexia
☐Weight Loss ☐Night Sweats ☐Hemoptysis
Date of Symptom Onset: **Weight Loss Amount:**

Household:
Number of Adults =
Number of Children =
☐ Newborn/Child < 1 year old
☐ Immunocompromised Family Member

Current TB Drug Regimen
☐**Isoniazid** _____ **mg** ☐**Pyrazinamide** _____ **mg**
☐**Rifampin** _____ **mg** ☐**Vitamin B-6** _____ **mg**
☐**Ethambutol** _____ **mg**
Medication Start Date: **Pt Weight:**

DISCHARGE PLANNING

Anticipated Discharge Date:

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

ALTERNATIVE DIAGNOSIS FOR DISCHARGE:

Treatment Plan:

Primary Medical Provider: **Phone:** **Follow-up Appt Date & Time:**	**MD for TB Treatment After Discharge:** **Phone:** **Follow-up Appointment Date and Time:**
Completed By:	Phone: Fax: Date:

Discharge Approved: ☐ YES ☐ NO. If denied, see below for action required.

HEALTH OFFICER/ TB CONTROLLER RESPONSE

_____ _____
Signature **Date**