Santa Clara County
Tuberculosis GOTCH Approval Form

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

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

PATIENT INFORMATION

Name (Last, First, Middle):	MRN:	Race/Ethnicity:	Preferred Language:
			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 (mm/dd/yy) (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