CONTRA COSTA HEALTH

Discharge Checklist for Tuberculosis Plan of Care

Tel: (925) 313-6740 **Fax:** (925) 313-6465

Patients with active or suspected tuberculosis may only be discharged after Contra Costa Health (CCH) Tuberculosis Client Services (TBCS) Program reviews and signs approval on Section E of this form. Please submit ALL of the following at least 2 business days prior to anticipated discharge (at least 3 business days for non-Contra Costa County Residents)

- ❑ Hospital Discharge Approval Forms packet faxed to TBCS Program:
  - Completed Tuberculosis Discharge Approval Form (included in packet)
  - Discharge Checklist (this document)

- ❑ Medical records faxed to TBCS Program **OR** confirm with TBCS Program if patient records are available in Care everywhere.
  - Physician notes (H&P, Progress notes, Pulmonary/ID Consult notes, Other Consult notes, D/C summary)
  - Medication list & dosages (including non-TB medications)
  - Daily MAR of TB meds (to confirm daily observed therapy)
  - Diagnostic tests (AFB smear/culture, molecular tests, pathology)
  - Radiology reports (CXR, CT)
  - Lab Results (QFT, CBC, CMP, hepatitis serologies, HgbA1c or fasting glucose, urine pregnancy test if patient is of childbearing age, HIV)

- ❑ Required labs to be done prior to discharge (QFT, CBC, CMP, Hepatitis B/C Status, HgbA1c or fasting glucose, urine pregnancy test if patient is of childbearing age, HIV).

- ❑ Images from relevant CXRs and/or CTs, pls give copy to patient at discharge.

- ❑ Patient is scheduled for a follow-up appointment with their TB treating physician within 30 days of discharge.

- ❑ Patient educated about their condition and D/C plan.

- ❑ Please prescribe and fill 30 days of TB medications (medications should be administered in a single daily dose, i.e. not split dosing).

- ❑ TBCS Program Hours are Monday to Friday, 8:00 AM to 4:30 PM.

You will receive confirmation by call/fax within 24-48 hours of submitting the discharge "Gotch Form" Plan of Care form information.

CONTRA COSTA HEALTH

Tuberculosis "Gotch Form" Plan of Care Discharge Approval Form

MANDATORY REPORTING: Per State of California Health and Safety Code Sections 121361(a)(1) and 121362, all health facilities shall not discharge, transfer, or release a patient until notification and a written plan has been submitted and approved by the Local Health Officer/TB Controller for all people known or suspected to have active tuberculosis. This form must be completed to carry out the department's legal obligation. **Please contact the TBCS Program at least 2 business days prior to the anticipated discharge time, or at least 3 business days if patient is a non-Contra Costa resident.**

Section A: Patient Information

Name: _____ Alias (if any): _____ Gender: ☐ M ☐ F ☐ Other: _____

Address: _____

Date of Birth: _____ Phone: _____ Primary Language: _____

Race/Ethnicity: _____ Country of Origin: _____ Date Arrived (in the US): _____

Occupation: _____ Medical Insurance: _____ Last 4 digits of SSN: _____

Emergency Contact: _____ Phone: _____

Section B: Hospital Information

Date of Admission: _____ Medical Record Number.: _____

Institution/Hospital: _____ Resident/Attending: _____

Room/Location: _____ Provider Contact: _____ (pager/cell)

Section C: Patient TB Information

Status: ☐ Lab Confirmed ☐ Suspected Date of TB Diagnosis: _____ Symptom Onset: _____

Date Reported to Health Department/TB Control: _____

Immunocompromised: ☐ Yes ☐ No Psychiatric Evaluation: ☐ Yes ☐ No

Substance Use Disorder: ☐ Yes ☐ No Psychiatric Disability: ☐ Yes ☐ No

Unhoused/Marginally Housed: ☐ Yes ☐ No Cognitive Deficit: ☐ Yes ☐ No

Test	Date	Result
Current: ☐ PPD/TST ☐ QFT/IGRA		☐ Pos_mm__ ☐ Neg ☐ Pos_ ☐ Neg
Initial CXR		Attach Report
Most Recent CXR		Attach Report

Current Symptoms: ☐ Cough ☐ Fever/Chills ☐ Weight loss ☐ Night sweats

Initial Bacteriology

Date Collected	Source/Site	AFB Smear Results	NAAT/PCR	AFB Culture Results
		☐ Pos ☐ Neg	☐ Pos ☐ Neg ☐ N/A	☐ Pos ☐ Neg ☐ Pend
		☐ Pos ☐ Neg	☐ Pos ☐ Neg ☐ N/A	☐ Pos ☐ Neg ☐ Pend
		☐ Pos ☐ Neg	☐ Pos ☐ Neg ☐ N/A	☐ Pos ☐ Neg ☐ Pend

Current Bacteriology				
Date Collected	**Source/Site**			
		☐ Pos ☐ Neg	☐ Pos ☐ Neg ☐ N/A	☐ Pos ☐ Neg ☐ Pend
		☐ Pos ☐ Neg	☐ Pos ☐ Neg ☐ N/A	☐ Pos ☐ Neg ☐ Pend
		☐ Pos ☐ Neg	☐ Pos ☐ Neg ☐ N/A	☐ Pos ☐ Neg ☐ Pend

Section D: Discharge Information

Current TB Treatment Start Date: _____

Site of Disease: ☐ Pulmonary ☐ Extrapulmonary (specify): _____

Medication	Dosage/Frequency	Medication	Dosage/Frequency
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	
Test Date	**Result**	**Test Date**	**Result**
HIV:		Hepatitis C Ab:	
Hepatitis B Ab/Ag:			

Patient's current standing weight: _____lbs. Anticipated discharge date: _____ and total days hospitalized:_____

Discharge to: ☐ Home ☐ Shelter ☐ SNF ☐ Jail/Prison ☐ Other (specify) _____

Please list address: _____

Referrals Prior to discharge: ☐ Home Health ☐ Hospice/Palliative Agency Name: _____

Primary Medical Doctor (PMD): _____Follow-up appointment: _____

Address/Institution: _____

Phone: _____ Fax: _____

Infectious Disease Doctor (ID): _____Follow-up appointment: _____

Address/Institution: _____

Phone: _____ Fax: _____

Name: _____ Fax: _____

Fax this form to the TBCS Program fax at fax # (925) 313-6465. DO NOT discharge patient until final approval is obtained from the TBCS Program.

Section E: FOR CONTRA COSTA HEALTH USE ONLY

Expected adherence to TB medication: ☐ Good ☐ Intermediate ☐ Poor

Will patient be on DOT? ☐ Yes ☐ No If yes, where will DOT be administered: _____

Transportation from hospital/to clinic: ☐ Has personal transport ☐ Needs personal transport ☐ OK for public transport

Contacts/Household Composition (if known) Initiated: ☐ Yes ☐ No

Discharge or Transfer Approved: ☐ Yes ☐ No

Actions required prior to discharge:

_____

_____

Completed by: _____

Name Title Date

Follow-up CCH TB Clinic Appointment Date: _____

Signature: _____ Date: _____