City and County of San Francisco

Department of Public Health

Tuberculosis Control Section

Susannah Graves, MD MPH – TB Controller

Discharge Checklist for Tuberculosis "Gotch" Plan of Care

Tel: (628) 206-8524 **Fax:** (628) 206-4565

Patients with active or suspected tuberculosis may only be discharged after DPH review and signed approval on Section E of this form
Please submit ALL of the following 24 hours prior to anticipated discharge (48 hours for non-San Francisco Residents)

- ❑ Hospital Discharge Approval Forms packet faxed to TB Control:
  - Completed Tuberculosis Discharge Approval Form (included in packet, can also be found at: http://sfcdcp.org/tbhospitaldischarge.html)
  - Discharge Checklist (this document)

- ❑ Medical records faxed to TB Control (faxing required only from the following hospitals: Kaiser, Dignity Health, Chinese Hospital):
  - 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, CRP, urine pregnancy test if patient is of childbearing age)

- ❑ Required labs to be done prior to discharge (QFT, CBC, CMP, hepatitis, HgbA1c or fasting glucose, CRP, urine pregnancy test if patient is of childbearing age).

- ❑ Images from relevant CXRs and/or CTs burned onto CD and given to patient at discharge.

- ❑ Patient is scheduled for a follow-up appointment at the TB Clinic if SF resident (non-San Francisco residents need ID follow-up appointment within 30 days at county of destination).

- ❑ Patient educated about their condition and D/C plan and have met Disease Control Investigator.

- ❑ For San Francisco residents, do not prescribe or fill any TB medications. For non-San Francisco residents, please prescribe and fill 30 days of TB medications (medications should be administered in a single daily dose, i.e. not split dosing) – please only dispense what is instructed by TB Control.

- ❑ Discharges will not be approved on weekends/holidays.

- ❑ TB Control Business Hours are Monday to Friday, 8:30 AM to 5:00 PM.

You will receive confirmation by call/fax within 24-48 hours of submitting the discharge "Gotch" Plan of Care form information. If you have any questions regarding procedures, please contact the San Francisco Tuberculosis Control Program Surveillance Chief, Felix Crespin, at phone number (628) 206-3398.

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Tuberculosis "Gotch" 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 TB Control Office at least 24 hours prior to the anticipated discharge time, or 48 hours if patient is a non-San Francisco 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	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

Section D: Discharge Information

Current TB Treatment Start Date: _____/_____/_____

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

Medication	Dosage/Frequency	Medication	Dosage/Frequency
1. Rifampin/Rifabutin		6. Fluoroquinolone:	
2. Isoniazid		7. Linezolid	
3. Pyrazinamide		8. Bedaquiline	
4. Ethambutol		9. Pretomanid	
5. Pyridoxine		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: (_____) _____

***To whom should DPH return a copy of this form, "TB Discharge Approval Form," once Section E is completed?

Name: _____ Fax: (_____) _____

Fax this form to Susannah Graves, MD, MPH, TB Controller at fax # (628) 206-4565. DO NOT discharge patient until final approval is obtained from TB Control.

Section E: FOR DPH 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 TB Clinic Appointment Date: _____/_____/_____

Signature: _____ Date: _____/_____/_____

Review Time (min/initials): Surveillance: ____/___ Nursing:____/_____ ____/_____ MD:____/____ Other:___/____