**Latent TB Medication Prescription and Order Form**

**Please Fax to 519-663-8241**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Health Care Provider Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: |  | | | | | | | | | |  | | | | | | | | | | | | | | Date: | | | | | | |  | | | | | | |
|  | Last | | | | | | | | | | First | | | | | | | | | | | | | |  | | | | | (YYYY/MMM/DD) | | | | | | | | |
| Address: |  | | | | | | | | | | | | | | | | | | | | | | | | City/Town: | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Postal Code: | |  | | | | | | | | | Phone: | | | |  | | | | | | | | | | Fax: | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Patient Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: |  | | | | | | | | | |  | | | | | | | | | | | | | | DOB: | | | | | | |  | | | | | | |
|  | Last | | | | | | | | | | First | | | | | | | | | | | | | |  | | | | | (YYYY/MMM/DD) | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: |  | | | | | | | | | | | | | | | | | | | | | | | | City/Town: | | | | | | |  | | | | | | |
|  |  | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| Postal Code: | |  | | | | | | | | | Phone: | | | |  | | | | | | | | | | Gender: | | | | | | |  | M | |  | |  | F |
|  |  | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| ***For information on the treatment of inactive TB please call the Infectious Disease Control Team***  ***at: (519) 663-5317 or visit our website at*** [***https://www.healthunit.com/tb-healthcare-providers***](https://www.healthunit.com/tb-healthcare-providers) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Initial TB Medication Prescription and Order** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Length of treatment | | | | | | | |  | |  |  | | | | |  | |  | | | | | |  |  | | | | | | |  |  | | | | | |
|  | | |  | | | 4 months | | | |  | 6 months | | | | |  | | 9 months | | | | | |  | 12 months | | | | | | |  | Other \_\_\_\_\_\_\_\_\_\_ | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medication Name | | | | | | | Dose (mg) | | | | Quantity | | | | | Prescribing MD | | | | | | | | | | | | Date Required for Pick Up | | | | | | | | | | |
|  | | | | | | |  | | | |  | | | | |  | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | |  | | | |  | | | | |  | | | | | | | | | | | |  | | | | | | | | | | |
| Date: |  | | | | | | | | | | | | | | | Signature: | | | | |  | | | | | | | | | | | | | | | | | |
|  | (YYYY/MMM/DD) | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | | |
| **For MLHU Use Only** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medication Name | | Dose (mg) | | | | | | | Quantity | | | | | Lot Number | | | | | | Expiry Date | | | | | | Packing Date | | | | | | | | | | Initial | | |
|  | |  | | | | | | |  | | | | |  | | | | | |  | | | | | |  | | | | | | | | | |  | | |
|  | |  | | | | | | |  | | | | |  | | | | | |  | | | | | |  | | | | | | | | | |  | | |
| ***Please note: It is our practice to provide up to 4 months of medication per client per order.***  ***To re-order, please fill in the appropriate refill section below and fax to 519-663-8241*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **REFILLS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Refill #1** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Number of Months Completed to Date | | | | | | | | | | | | |  | | | 3 months | | | | |  | | 6 months | | | |  | | | | 9 months | | |  | Other \_\_\_\_\_\_\_ | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medication Name** | | | | **Dose (mg)** | | | | | | | **Quantity** | | | | | **Prescribing MD** | | | | | | | | | | | | **Date Required for Pick Up** | | | | | | | | | | |
|  | | | |  | | | | | | |  | | | | |  | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | |  | | | | | | |  | | | | |  | | | | | | | | | | | |  | | | | | | | | | | |
| Date: |  | | | | | | | | | | |  | | |  |  | | | Signature: | | |  | | | | | | | | | | | | | | | | |
| (YYYY/MMM/DD) | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| **For MLHU Use Only** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medication Name | | Dose (mg) | | | | | | | Quantity | | | | | Lot Number | | | | | | Expiry Date | | | | | | Packing Date | | | | | | | | | | Initial | | |
|  | |  | | | | | | |  | | | | |  | | | | | |  | | | | | |  | | | | | | | | | |  | | |
|  | |  | | | | | | |  | | | | |  | | | | | |  | | | | | |  | | | | | | | | | |  | | |
| **Refill #2** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Number of Months Completed to Date | | | | | | | | | | | | |  | | | 3 months | | | | |  | | 6 months | | | |  | | | | 9 months | | |  | Other \_\_\_\_\_\_\_ | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medication Name** | | | | | **Dose (mg)** | | | | | | **Quantity** | | | | | **Prescribing MD** | | | | | | | | | | | | | **Date Required for Pick Up** | | | | | | | | | |
|  | | | | |  | | | | | |  | | | | |  | | | | | | | | | | | | |  | | | | | | | | | |
|  | | | | |  | | | | | |  | | | | |  | | | | | | | | | | | | |  | | | | | | | | | |
| Date: |  | | | | | | | | | | |  | | |  |  | | | Signature: | | |  | | | | | | | | | | | | | | | | |
|  | (YYYY/MMM/DD) | | | | | | | | | | |  | | |  |  | | |  | | |  | | | | | | | | | | | | | | | | |
| **For MLHU Use Only** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medication Name | | Dose (mg) | | | | | | | Quantity | | | | | Lot Number | | | | | | Expiry Date | | | | | | Packing Date | | | | | | | | | | Initial | | |
|  | |  | | | | | | |  | | | | |  | | | | | |  | | | | | |  | | | | | | | | | |  | | |
|  | |  | | | | | | |  | | | | |  | | | | | |  | | | | | |  | | | | | | | | | |  | | |

August 24, 2023