**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