Latent Tuberculosis Infection (LTBI) 3HR

MEDICATION PRESCRIPTION

Patient information:

Patient Name (last, first): _____

Date of birth (DD/MM/YYYY): _____

Weight (lbs. or kg): _____

Treatment regimen:

Maximum Dose

☐ Isoniazid 300mg
Qty.: 30
Sig. Take 1 tab once daily
Refills: 2
AND

☐ Rifampin 300mg
Qty.: 60
Sig. Take 2 caps once daily
Refills: 2

Alternative Dose

☐ Isoniazid mg
Qty.:
Sig: Take caps (mg) once daily
Refills:
AND

☐ Rifampin mg
Qty.:
Sig: Take tabs (mg) once daily
Refills:

Date of order: _____

Language preference on label (English is default): _____

Comments:

Clinic information:

NPI (national provider identification number): _____

Provider's name (print): _____

Provider's signature: _____

Clinic name: _____

Address: _____

_____

Phone number: _____ Fax number: _____

DEPARTMENT OF HEALTH

Minnesota Department of Health
Tuberculosis Prevention and Control
651-201-5414 | 1-877-676-5414
Fax: 1-800-296-0993