Manitoba

Active/Suspected TB Prescription

Fax Prescription to:

O The Prescription Shop
3-555 Balmoral Street, Winnipeg, MB
Fax: 204-944-0957
Phone: 204-944-0954

O Grand Medicine Health Services
(For FNIHB Clients in Rural/Remote Areas as of July 1, 2017)
Suite A 220 Cree Crescent Winnipeg, MB
Fax: 204-885-7504 Phone: 204-885-0768

O Other:

To the Pharmacist:

This prescription is:

O New prescription

O Addition to previous prescription

O Replace previous prescription

O Begin after previous prescription complete

Please supply as:

O blister pack *(default unless specified)*

O bulk bottle

O liquid bulk bottle

O liquid unit dose

Additional dispensing info:

OTHER (e.g., Shipping Address):

Hospital use only (inpatient doses received):

Date Started: ____ (MM) / ____ (DD) / ____ (YYYY)

RIF: _____ mg PO X _____ doses

INH: _____ mg PO X _____ doses

EMB: _____ mg PO X _____ doses

PZA: _____ mg PO X _____ doses

MFX: _____ mg PO X _____ doses

LFX: _____ mg PO X _____ doses

Other: _____

Patient Name: ..... Date: .....

DOB: ..... PHIN: ..... Gender: M / F

Address: .....

Treaty #: ..... Band: .....

Weight: ..... Allergies: .....

Active/Suspected TB Treatment Prescription

Choose one or more of the following as applicable:

Intensive A

O **Daily** O **3 x weekly** O **5 x weekly** O **Other:** _____

Isoniazid _____ mg PO X _____ doses

RifAMPin _____ mg PO X _____ doses

Pyrazinamide _____ mg PO X _____ doses

Ethambutol _____ mg PO X _____ doses

Pyridoxine _____ mg PO X _____ doses

Other: _____

Intensive B to start after "A" is completed if applicable

O **Daily** O **3 x weekly** O **5 x weekly** O **Other:** _____

Isoniazid _____ mg PO X _____ doses

RifAMPin _____ mg PO X _____ doses

Pyrazinamide _____ mg PO X _____ doses

Ethambutol _____ mg PO X _____ doses

Pyridoxine _____ mg PO X _____ doses

Other: _____

Continuation

O **Daily** O **3 x weekly** O **Other:** _____

Isoniazid _____ mg PO X _____ doses

RifAMPin _____ mg PO X _____ doses

Pyridoxine _____ mg PO X _____ doses

Other: _____

Other: _____

Prescriber Signature: .....

Prescriber Name: ..... License No.: .....

Address: .....

Tel.: ..... Fax: ..... Date: .....