

**Fax Prescription to:**

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

**To the Pharmacist:**

**This prescription is:**

- New prescription
- Addition to previous prescription
- Replace previous prescription
- Begin after previous prescription complete

**Please supply as:**

- blister pack (*default unless specified*)
- bulk bottle
- liquid bulk bottle
- 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**

- Daily  3 x weekly  5 x weekly  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

- Daily  3 x weekly  5 x weekly  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**

- Daily  3 x weekly  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: .....

Prescriber Certification: This prescription represents the original of the prescription drug order. The pharmacy addressee noted above is the only intended recipient and there are no others. The original prescription has been invalidated and securely filed, and it will not be transmitted elsewhere at another time by the prescriber. Quantity must be stated in words and numerals. THIS TELECOPY IS CONFIDENTIAL AND IS INTENDED TO BE RECEIVED BY THE ADDRESSEE ONLY. IF THE READER IS NOT THE INTENDED RECIPIENT THEREOF, YOU ARE ADVISED THAT ANY DISSEMINATION, DISTRIBUTION OR COPYING OF THIS FACSIMILE IS STRICTLY PROHIBITED. Use of this form for purposes or by persons, not authorized under the Controlled Drugs and Substances Act and its Regulations is a criminal offence.