Manitoba

Active/Suspected TB Prescription

Fax Prescription to (choose the one appropriate):

○ **The Prescription Shop**
3-555 Balmoral Street, Winnipeg, MB
🖷 204-944-0957 ☎ 204-944-0954

○ **Shawano Pharmacy**
550-360 Broadway Avenue, Winnipeg, MB
🖷 204-944-1540 ☎ 204-944-1577

- **For FNIHB clients in Berens River, Bloodvein, Brokenhead, Hollow Water, Little Black River, Little Grand Rapids, Pauingassi, Poplar River**

○ **SpiritRx Services** (formerly Grand Medicine)
15-801 Century Street, Winnipeg, MB R3H 0C3
🖷 204-885-7504 ☎ 204-885-0768

- **For all other rural/remote FNIHB communities**

○ **Other:**

To the Pharmacist

This prescription is:

○ new prescription

○ addition to previous prescription

○ to replace previous prescription

○ to 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: .....