

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:

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.