Latent Tuberculosis Infection (LTBI) 3HR

MEDICATION PRESCRIPTION

Patient information:

Patient Name (last, first): ______________________ DOB (DD/MM/YYYY): __________

Address: ____

Weight (lbs. or kg): ______________ Phone number: ______________________

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 (select/circle): English Spanish

Comments:

Clinic information:

NPI (national provider identification number): ______________________

Provider's name (print): ______________________

Provider's signature: ______________________

Clinic name: ______________________

Address: ______________________

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Phone number: ______________ Fax number: ______________

DEPARTMENT OF HEALTH

Minnesota Department of Health
Tuberculosis Prevention and Control
651-201-5414 | 1-877-676-5414
Fax: 651-201-5500

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