Latent Tuberculosis Infection (LTBI) 4R, 6H, or 9H

MEDICATION PRESCRIPTION

Patient information:

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

Address: _____

Weight (lbs. or kg): _____ Phone Number: _____

Treatment regimen:

Maximum Dose

☐ Rifampin 300mg

Qty: 60

Sig: Take 2 caps once daily

Refills:

OR

☐ Isoniazid 300mg

Qty: 30

Sig: Take 1 tabs once daily

Refills:

Alternative Dose

☐ Rifampin mg

Qty:

Sig: Take caps once daily

Refills:

OR

☐ Isoniazid mg

Qty:

Sig: Take caps once daily

Refills:

Date of order: _____

Language preference on label (English is default): ☐ English ☐ Spanish

Comments:

Clinic information:

NPI (national provider identification number): _____

Provider's name (print): _____

Provider's signature: _____

Clinic name: _____

Address: _____

_____

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