

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

MEDICATION PRESCRIPTION

Patient information:

Patient Name (last, first): _____

Date of birth (DD/MM/YYYY): _____

Weight (lbs. or kg): _____

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): _____

Comments:

Clinic information:

NPI (national provider identification number): _____

Provider's name (print): _____

Provider's signature: _____

Clinic name: _____

Address: _____

Phone number: _____

Fax number: _____