TORONTO Public Health

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TPH Client ID #:

Notification of TB Infection and TB Preventive Treatment Order Form

☐ **Reporting Positive Skin Test / IGRA Test Results** ☐ **Ordering TB Medications**

Last Name, First Name, Middle/Second Name			Gender ☐ Male ☐ Female ☐ Other
OHIP Number	Date of Birth yyyy/mm/dd		Country of Birth
Address	City	Postal Code	Telephone No.

Reason for Test:			
☐ Contact (exposure within past 2 years) ☐ Work/Volunteer Screening ☐ Immigration ☐ HIV/AIDS ☐ Other immunosuppressive condition or therapy	**TST**	Date Planted: yyyy/mm/dd Date Read: yyyy/mm/dd	Result: mm induration
	IGRA (If available)	Date: yyyy/mm/dd	Result: *attach copy of lab result
	CXR*	Date: yyyy/mm/dd	Result: *attach copy of report
	HIV (If available)	Date: yyyy/mm/dd	Result:

TB Preventive Treatment: *Defer medication order until TB disease is ruled out (and sputum results are available, if collected)	☐ **No -** Declined by client, counselled on signs and symptoms of TB disease. ☐ **No -** Not recommended, counselled on signs and symptoms of TB disease.
	TB disease (active TB) ruled out ☐ **Yes** Planned Length of Treatment (in months): ☐ **4** ☐ **6** ☐ **9**

Fax Completed Forms and Attachments to Fax Number: 416-338-8149

1. Complete all fields or your order will **NOT** be processed. You may be contacted for additional information/pending results.
2. Attach a copy of the chest x-ray report done within 6 months (3 months for contacts with recent exposure in past 2 years).

	Regimen	**Prescription**		**Medication Strength Available**	**Quantity per Bottle**
First-line regimen	Rifampin daily x 4 months	Standard dosage: ☐	600 mg oral daily	300 mg capsule	100
		Other dosage: ☐	________ mg oral	150 mg capsule	100
Second-line regimen	Isoniazid daily x 9 months	Standard dosage: ☐	300 mg oral daily	300 mg tablet	100
		Other dosage: ☐	________ mg oral	100 mg tablet	100
				50 mg/5ml (Syrup)	500 ml
	Pyridoxine Hydrochloride (B6)	Standard dosage: ☐ Other dosage: ☐	25 mg oral daily ________ mg oral	25 mg tablet	100

Additional Information:

Clinician's Full Name: ________________ Signature: ________________ Billing No.: ____________

Address: ________________________________ Postal Code: ____________

Tel No.: ________________ Fax No.: ________________ Date: ____________ yyyy/mm/dd

For TPH Use Only:
Date Ordered:______________ Conf.#: ______________ Initial: ______________