MIDDLESEX-LONDON HEALTH UNIT
BUREAU DE SANTÉ DE MIDDLESEX-LONDON
www.healthunit.com

Latent TB Medication Prescription and Order Form
Please Fax to 519-663-8241

Health Care Provider Information

Name: ______________________ Date: ______________
Last First (YYYY/MMM/DD)

Address: ______________________ City/Town: ______________

Postal Code: __________ Phone: __________ Fax: __________

Patient Information

Name: ______________________ DOB: ______________
Last First (YYYY/MMM/DD)

Address: ______________________ City/Town: ______________

Postal Code: __________ Phone: __________ Gender: ☐ M ☐ F

For information on the treatment of inactive TB please call the Infectious Disease Control Team at: (519) 663-5317 ext. 2330 or visit our website at https://www.healthunit.com/tb-healthcare-providers

Initial TB Medication Prescription and Order

Length of treatment

☐ 4 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other ________

Medication Name	Dose (mg)	Quantity	Prescribing MD	Date Required for Pick Up

Date: ______________ Signature: ______________
(YYYY/MMM/DD)

For MLHU Use Only

Medication Name	Dose (mg)	Quantity	Lot Number	Expiry Date	Packing Date	Initial

Please note: It is our practice to provide up to 4 months of medication per client per order. To re-order, please fill in the appropriate refill section below and fax to 519-663-8241

REFILLS

Refill #1

Number of Months Completed to Date ☐ 3 months ☐ 6 months ☐ 9 months ☐ Other ________

Medication Name	**Dose (mg)**	**Quantity**	**Prescribing MD**	**Date Required for Pick Up**

Date: ______________ Signature: ______________
(YYYY/MMM/DD)

For MLHU Use Only

Medication Name	Dose (mg)	Quantity	Lot Number	Expiry Date	Packing Date	Initial

Refill #2

Number of Months Completed to Date ☐ 3 months ☐ 6 months ☐ 9 months ☐ Other ________

Medication Name	**Dose (mg)**	**Quantity**	**Prescribing MD**	**Date Required for Pick Up**

Date: ______________ Signature: ______________
(YYYY/MMM/DD)

For MLHU Use Only

Medication Name	Dose (mg)	Quantity	Lot Number	Expiry Date	Packing Date	Initial