TORONTO Public Health

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TPH Client ID #:
Clear Form

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		Result: mm induration
	Date Read: yyyy/mm/dd		
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 Other dosage: ☐ _____ mg oral	300 mg capsule	100
			150 mg capsule	100
Second-line regimen	Isoniazid daily x 9 months	Standard dosage: ☐ 300 mg oral daily Other dosage: ☐ _____ mg oral	300 mg tablet	100
			100 mg tablet	100
			50 mg/5ml (Syrup)	500 ml
	Pyridoxine Hydrochloride (B6)	Standard dosage: ☐ 25 mg oral daily Other dosage: ☐ _____ 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: _____