

Please note: Initial drug order requires TB Skin Test Date and Result in mm of induration and copy of the chest x-ray report done within the last six months to rule out active disease. **DRUG ORDERS WILL NOT BE PROCESSED WITHOUT THIS INFORMATION**

Reporting positive skin test only

Ordering TB Drugs

Patient's Last Name	First Name	Initial	Date of Birth	Yr.	Mo.	Day	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Address			Telephone No. Home: _____ Bus: _____				
Country of Birth	Date of Arrival in Canada	Yr.	Mo.	Day	OHIP		iPHIS #

Method of Detection <input type="checkbox"/> Routine <input type="checkbox"/> Contact of a case <input type="checkbox"/> Symptoms (specify) _____ _____	Medical Risk Factors <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Diabetes <input type="checkbox"/> Renal Disease <input type="checkbox"/> Immunosuppressive therapy / disease <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown <input type="checkbox"/> None
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Chest X-Ray Date _____ <input type="checkbox"/> Abnormal <input type="checkbox"/> Normal Attach a copy of chest x-ray done within last six months	Mantoux Date _____ Result _____ mm Mantoux Date _____ Result _____ mm HIV Testing Date _____ Result _____
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LTBI Treatment (please circle length of treatment) <input type="checkbox"/> Pyridoxine 25 mg po daily x 6 9 12 months <input type="checkbox"/> INH 300 mg po daily x 6 9 12 months <input type="checkbox"/> RMP 450 mg po daily x 4 6 9 12 months <input type="checkbox"/> RMP 600 mg po daily x 4 6 9 12 months <input type="checkbox"/> INH syrup _____ mg po daily x 6 9 12 months <input type="checkbox"/> Other _____ Weight _____ kg Recommended INH dosage for children is 10-15 mg/kg up to a maximum of 300mg	Treatment Start Date Initial Order Date _____ 1 st Repeat Date _____ 2 nd Repeat Date _____ 3 rd Repeat Date _____ Comments _____ _____ _____	Treatment End Date _____ (YYYY/MM/DD) Reason Treatment Ended <input type="checkbox"/> Adequate Treatment <input type="checkbox"/> Side Effects <input type="checkbox"/> Non-compliant <input type="checkbox"/> Other
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Physician Name _____ Address _____ Phone No _____ Fax No _____ Signature _____	Please Complete and Return To: Peel Public Health Communicable Disease Control 7120 Hurontario St., P.O. Box 630 RPO Streetsville Mississauga, ON L5M 2C1 Phone: 905-791-7800 ext 2538, 2539, 2458, 2796 Fax: 905-565-8428
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