DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44126 (02/2024)

STATE OF WISCONSIN
Tuberculosis Dispensary Program
608-261-6319
FAX 608-266-0049

MEDICATION REFILL REQUEST

Requests for additional medication must be submitted 1-2 weeks before the client needs a refill. Failure to complete all information requested on this form may delay receipt of medication.

Client name	WEDSS ID number
Client's date of birth (MM/dd/yyyy)	
Date of request (MM/dd/yyyy)	Local Health Department name

Change in insurance status? ☐ Yes* ☐ No

*If yes, please include insurance numbers (below) or a scanned copy of the patient's insurance card(s).

COMPLETE ITEMS BELOW

Change in patient weight? ☐ Yes* ☒ No
*If yes, please provide updated weight information:
Patient Weight _____ ☐ kg. ☐ lbs. Date weight recorded _____

Medication	**Dosage and Frequency**
Isoniazid (INH)	☐ 300 mg ☐ _____ mg ☐ Daily ☐ Other _____
Rifampin (RIF)	☐ 600 mg ☐ _____ mg ☐ Daily ☐ Other _____
Pyrazinamide (PZA)	☐ 1000 mg ☐ 1500 mg ☐ 2000 mg ☐ _____ mg ☐ Daily ☐ Other _____
Ethambutol (EMB)	☐ 800 mg ☐ 1200 mg ☐ 1600 mg ☐ _____mg ☐ Daily ☐ Other _____
B6	☐ 25 mg ☐ 50 mg ☐ Daily
Other (please specify)	

Return to:
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