DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44000 (10/2018)

STATE OF WISCONSIN
s. 252.10 (7), Wis. Stats.
Wisconsin Tuberculosis Program
Telephone: 608-261-6319

TUBERCULOSIS DISEASE
INITIAL REQUEST FOR MEDICATION

Fields marked with an (*) asterisk are required. Please complete patient information on reverse side.
Submit completed form to the Local Health Department.

SUBMIT COMPLETED FORM TO: **Local Health Department (LHD)**	**LHD Fax Number**

*NAME –Patient (Last, First, Middle Initial)	*Date of Birth (mm/dd/yyyy)
*Address (Street or Rural Route)	*Telephone Number
*City *Zip Code *LHD/Clinic to Send Meds	Other contact, as needed

*Sex	*Race	*Ethnicity ☐ Hispanic ☐ Non-Hispanic	*Weight	*Prescription Insurance Provider & Insurance No.

*NAME – Clinician (Print clearly)	NAME - Hospital/Clinic/Facility
*Address (Street, City, State, Zip code)	*Telephone Number

*MEDICATION ORDERS (Check mg/kg for patients with variable weight)

Medication	Dose	Frequency	Duration of Therapy
Isoniazid (INH) (Generic only)	☐ 300 mg ☐ _____ mg ☐ _____ mg/kg ***10-15 mg/kg infants + children; 5 mg/kg up to 100 lb/45.5 kg adults; 300 mg maximum daily all others***	☐ Daily ☐ Other _____	☐ 6 mo ☐ 9 mo ☐ Other _____
Rifampin (Generic only)	☐ 600 mg ☐ _____ mg ☐ _____ mg/kg ***10-20 mg/kg infants + children; 10 mg/kg up to 100 lb/45.5 kg adults; 600 mg maximum daily all others***	☐ Daily ☐ Other _____	☐ 6 mo ☐ 9 mo ☐ Other _____
Ethambutol (Generic only)	☐ 800 mg ☐ 1200 mg ☐ 1600 mg ☐ _____ mg ☐ _____ mg/kg ***20 mg/kg infants + children; 40-55 kg, 800 mg; 56 – 75 kg, 1200 mg; 76 – 90 kg, 1600 mg; long term EMB=15mg/kg***	☐ Daily ☐ Other _____	☐ 2 mo ☐ 6 mo ☐ Other _____
Pyrazinamide	☐ 1000 mg ☐ 1500 mg ☐ 2000 mg ☐ _____ mg ☐ _____ mg/kg ***30-40 mg/kg infants + children; 40 – 55 kg, 1000 mg; 56 – 75 kg, 1500 mg; 76 – 90 kg, 2000 mg; long-term PZA=25mg/kg***	☐ Daily ☐ Other _____	☐ 2 mo ☐ 6 mo ☐ Other _____

☐ **Vitamin B6** (pyridoxine) _____ mg ☐ Daily ☐ Other _____ ☐ 9 mo ☐ Other _____
10 – 50 mg/day when on INH

☐ **Multivitamin** One tab daily _____ ☐ 9 mo ☐ Other _____
To include Vitamin D ≥ 400 IU (10 mcg) for infants 0 – 12 months, 600 IU (15 mcg) for children and adults; for the duration of the prescription.

☐ **Other:** _____

☐ **Other:** _____

Standard of care: All medications are given together under directly observed therapy (DOT). Medications are administered seven (7) days per week for at least the first two weeks of therapy. Then medications may be administered five (5) days per week by DOT, with the remaining two doses self-administered over the weekend. Medications for those expected to gain weight during therapy are written as mg/kg; the nurse will weigh the person weekly and drug dosage will be adjusted to maintain the mg/kg dose as closely as can be measured. Adjustments to dose, frequency, and duration of therapy are common and depend upon the individual patient's disease and response to therapy.

MONITORING ORDERS

1. Beginning with the third week of therapy, collect one sputum sample weekly and send to WSLH for smear and culture.
2. Assess the patient at least weekly for side effects and medication toxicity. Hold medications and call clinician if present.

SIGNATURE

***SIGNATURE** – Clinician: _____ * Date Prescription Ordered: _____

WEDSS Disease Incident Number	Ship medication to:
Pharmacy: ☐ Skywalk ☐ Other, List	

Patient Name: **WEDSS Disease Incident No.**

PATIENT INFORMATION (*Required)

A. *Tests:

1. T-Spot™ blood assay: Date Drawn: _____ **Results:** ☐Positive ☐Negative ☐Indeterminate ☐Invalid
2. Quantiferon™ (QFT) blood assay: Date Drawn: _____ **Results:** ☐Positive ☐Negative ☐Indeterminate

OFT Numeric results: Nil _____ IU/mL TB Nil _____ IU/mL Mitogen _____ IU/mL

3. Tuberculin Skin Test: Date Applied: _____ Date Read: _____ Results **(induration only)** _____ mm

4.

Specimen (Sputum or BAL)	Sample Date	Results		
		Smear	PCR	Culture
Other:				

5. Sputum/other culture: Specimen source: _____ Date positive culture reported _____

B. *Is patient symptomatic? (check all that apply) ☐ **No**

☐ Fever ☐ Night sweats ☐ Cough > 3 weeks ☐ Sputum ☐Blood in sputum ☐ Weight loss

☐ Other _____

C. *Reason for referral for treatment: (check all that apply)

☐ Suspect TB **disease** ☐ Confirmed TB **disease**
☐ Contact to a current or past case of TB: Name of case, if known _____

D. *Chest X-Ray or CT: (Include copy of chest x-ray and/or CT report with this request)

Date _____ **Results:** ☐ Normal ☐ Abnormal ☐ Cavitary

E. *Prior treatment for tuberculosis infection or disease?

☐ **NO** ☐ **YES** Please explain: _____

F. Risk factors for adverse reactions or non-adherence?

Specify _____

G. *Risk factors for drug-resistance or poor response to medication? (check all that apply)

☐ Born outside US, or parents born outside US Country of birth: _____ Year arrived in US: _____ ☐ NA

☐ Liver impairment (hepatitis, alcohol use, drug use, other _____)

☐ Diabetes: ☐ Insulin-dependent ☐ Oral hypoglycemic ☐ Poorly-controlled

☐ Immunosuppressed? Explain: _____

☐ Population risk factor (travel outside US, jail or prison in other state/country)

H. *Baseline blood tests

HIV	Date	Result
ALT/AST	Date	Result
CBC w/platelets	Date	Result
T. BIL	Date	Result
S. Creatinine	Date	Result
Uric Acid	Date	Result
Other:	Date	Result

References

Treatment of tuberculosis. *MMWR Recommendations and Reports*. 52:RR-11. June 20, 2003.
Red Book. American Academy of Pediatrics. 29th Edition. 2012.

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Clear Entire Form/Reset