



TUBERCULOSIS ROUTINE ORDERS

Patient: _____ DOB: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Country of Origin: United States Other: _____ Label pill bottle in Spanish

Mantoux test: ___/___/___ Induration: _____ QuantiFERON test: ___/___/___ Positive Neg Indeterminate

CXR: ___/___/___ Normal Abnormal but not consistent with active TB Other _____

- Does the patient have any drug allergies? No Yes – please specify _____
- Does the patient have a chronic medical condition? No Yes – please specify _____
- Is the patient currently taking any other prescription or non-prescription drugs? No Yes – If yes, please list them: _____

• Indication for TB Screening:

- | | | |
|---|---|--|
| <input type="checkbox"/> TB contact/exposure follow-up | <input type="checkbox"/> correctional facility inmate | <input type="checkbox"/> employee screening |
| <input type="checkbox"/> foreign-borne from high-prevalence area | <input type="checkbox"/> nursing home resident | <input type="checkbox"/> correctional facility |
| <input type="checkbox"/> CXR indicating stable, inactive TB | <input type="checkbox"/> homeless | <input type="checkbox"/> nursing home |
| <input type="checkbox"/> medical condition (e.g., HIV-infected, organ transplant, substance abuse, immunosuppression, diabetes) | <input type="checkbox"/> drug treatment facility resident | <input type="checkbox"/> home health care |
| | <input type="checkbox"/> migrant worker | <input type="checkbox"/> other health care |
| | <input type="checkbox"/> other _____ | <input type="checkbox"/> drug treatment facility |
| | | <input type="checkbox"/> homeless shelter |
| | | <input type="checkbox"/> other _____ |

• Has clinician ruled out active TB disease? Yes

• Other pertinent history: _____

MD ORDERS:

1. Public Health Nurse to teach regarding: • Tuberculosis • Medication Regimen • Follow up (i.e. labs, Dr. appts)

2. Public Health Nurse to review medications from MDH and distribute monthly to patient.

3. Public Health Nurse to visit monthly x _____ months as well as PRN visits/contacts to assess:
• Medication Compliance • Medication Side Effects • Signs and Symptoms of Tuberculosis Disease

4. Medications Prescribed:

___ Isoniazid 300 mg PO QD x _____ months - - - Patient's weight: _____ lbs/kg (required for children or if dose <300mg/day)

___ Rifampin 60 mg PO QD x _____ months

___ Vitamin B6 (pyridoxine Hydrochloride) 50 mg PO QD x _____ months. Indication for requesting Vitamin B6:

- | | | |
|--|--|---|
| <input type="checkbox"/> diabetes | <input type="checkbox"/> HIV | <input type="checkbox"/> infant who is >50% breastfed and taking INH; |
| <input type="checkbox"/> renal failure | <input type="checkbox"/> seizure disorder | recommended Vitamin B6 dose: |
| <input type="checkbox"/> alcoholism | <input type="checkbox"/> pregnancy/breastfeeding | 6.25 mg daily |
| <input type="checkbox"/> malnutrition | | |

___ Other meds and rationale for using them: _____

5. Other orders (labs, Dr. appts.) _____

I certify OTTER TAIL COUNTY PUBLIC HEALTH to follow this patient for the duration of therapy prescribed.

Physician's Signature _____ Date _____

Physician's Name (Please Print) _____