Centre de Santé et Services Sociaux Inuulitsivik
Inuulitsivik Health & Social Services Centre
Puvirnituq, Québec J0M 1P0
T 819 988-2957 / F 819 988-2796

UNGAVA TULATTAVIK HEALTH CENTER
CENTRE DE SANTÉ TULATTAVIK DE L'UNGAVA

EMBOSSER ICI LA CARTE DU CSI OU CSTU,
SI NON DISPONIBLE, INSCRIRE LES NOM, PRÉNOM,
DATE DE NAISSANCE ET NUMÉRO DE DOSSIER

EMBOSS THE CARD OF THE IHC OR UTHC HERE,
IF NOT AVAILABLE, WRITE THE NAME, SURNAME,
DATE OF BIRTH AND FILE NUMBER

TB Program
Medical prescription

TREATMENT FOR LATENT TUBERCULOSIS INFECTION – 3HP (Rifapentine and Isoniazid) DOT

Allergies: ☐ Nil or Specify: _____

Attention: Pregnancy and breastfeeding are contraindications.

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CHILD OR ADULT (2 to 65 years)

Date of the prescription: _____ /_____ /_____
YYYY-MM-DD

Weight: _____kg

3HP – Rifapentine (RPT) and Isoniazid (INH)
1 dose/week PO administered under directly observed therapy (DOT) x 12 weeks (maximum of 16 weeks)

Rifapentine (RPT) – Child or adult (2 to 65 years) (max.: 900 mg), thus:

- ☐ 10.0 - 14.0 kg: 300 mg
- ☐ 14.1 - 25.0 kg: 450 mg
- ☐ 25.1 - 32.0 kg: 600 mg
- ☐ 32.1 - 49.9 kg: 750 mg
- ☐ ≥ 50.0 kg: 900 mg

Isoniazid (INH) (max.: 900 mg), thus:
(Round up to the next 50 mg dose)

- ☐ Child (2 to 11 years): 25 mg/kg
- ☐ Adolescent or adult (12 to 65 years): 15 mg/kg

Pyridoxine (vitamin B6) - Child or adult (2 to 65 years):

- ☐ 2 mg/kg (max.: 50 mg)

TO BE COMPLETED BY THE PHARMACY:

RPT: _____ mg PO 1x/week X 12 doses

INH: _____ mg PO 1x/week X 12 doses

Vit. B6: _____ mg PO 1x/week X 12 doses

Signature : _____

Name: _____ License #: _____

I hereby attest that the present prescription, sent by fax or e-mail, shall be considered valid and the only original. The pharmacy mentioned below is the sole addressee. The prescription may not be reused or duplicated.

Check the village of origin and the pharmacy concerned:

Inuulitsivik Health Centre		**Ungava Tulattavik Health Centre**	
☐ *Salluit* 819 255-9090 ☐ *Ivujivik* 819 922-9090 ☐ *Akulivik* 819 496-9090 ☐ *Inukjuaq* 819 254-9090 ☐ *Umiujaq* 819 331-9090 ☐ *Kuujjuaraapik* 819 929-9090	☐ **VOYER PHARMACY, MONTRÉAL** Tel.: 1 877 426-0406 Fax: 1 877 426-0546 pharmacie.voyer.csi@ssss.gouv.qc.ca	☐ *Kangiqsualujjuaq* 819 337-9090 ☐ *Kuujjuaq* 819 964-2905 ☐ *Aupaluk* 819 491-9090 ☐ *Kangirsuk* 819 935-9090 ☐ *Quaqtaq* 819 492-9090 ☐ *Kangiqsujuaq* 819 338-9090 ☐ *Tasiujaq* 819 633-9090	☐ **TULATTAVIK PHARMACY, KUUJJUAQ** Tel.: 819 964-2905 # 201/277 Fax: 819 964-0035 pharmacy.kuujjuaq@ssss.gouv.qc.ca
☐ *Puvirnituq* 819 988-9090	☐ **INUULITSIVIK PHARMACY, PUVIRNITUQ** Tel.: 819 988-2957 #263 Fax: 819 988-2551 pharmacie.pov@ssss.gouv.qc.ca		