



Centre de Santé et Services Sociaux Inuulitsivik  
 Inuulitsivik Health & Social Services Centre  
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 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 DOSSIER  
 EMBOSS HERE THE CARD OF IHC OR UTHC,  
 IF NOT AVAILABLE, WRITE THE NAME, SURNAME,  
 DATE OF BIRTH AND FILE NUMBER

**Tuberculosis Program  
 Medical Prescription**

**WINDOW-PERIOD PROPHYLAXIS – CHILD AGED 2 to  
 4 years**

**3HP – RIFAPENTINE and ISONIAZID DOT**

Allergies:  Nil or specify: \_\_\_\_\_



**CHILD AGED 2 to 4 years**

Date of prescription: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 YYYYY MM DD

Weight : \_\_\_\_ kg

**3HP – rifapentine (RPT) and isoniazid (INH) administered once a week under DOT for the duration of the window-period or up to the equivalent of 12 doses/12 weeks**

WINDOW-PERIOD\* – Child aged 2 to 4 years

**Rifapentine (RPT)** (max.: 900 mg), as follows:

- 10-14.0 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), as follows:

(Round up to the next 50 mg dose)

- 25 mg/kg

**Pyridoxine (vit. B6)** (max.: 50 mg):

- 2 mg/kg

**TO BE COMPLETED BY THE PHARMACY:**

RPT: \_\_\_\_\_ mg PO 1x/week x 12 doses (maximum)

INH: \_\_\_\_\_ mg PO 1x/ week x 12 doses (maximum)

Vit. B6: \_\_\_\_\_ mg PO 1x/ week x 12 doses (maximum)

\* If POST-WINDOW PERIOD TST not significant, end 3HP window-period prophylaxis on medical prescription.  
 If POST-WINDOW PERIOD TST significant and active TB excluded, continue LTBI treatment with 3HP up to equivalent of 12 doses/12 weeks (including window-period) by completing 3HP prescription ([DSPu-TB\\_ITL\\_PRESC-MED-3HP\\_EN](#)) and 3HP monitoring protocol ([DSPu-TB\\_ITL\\_PROT-SUIVI-3HP\\_EN](#)).

Signature: \_\_\_\_\_

Licence #: \_\_\_\_\_

Name : \_\_\_\_\_

*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   |   |
|---|---|---|---|
| <input type="checkbox"/> Salluit 819 255-9090<br><input type="checkbox"/> Ivujivik 819 922-9090<br><input type="checkbox"/> Akulivik 819 496-9090<br><input type="checkbox"/> Inukjuaq 819 254-9090<br><input type="checkbox"/> Umiujaq 819 331-9090<br><input type="checkbox"/> Kuujuaaraapik 819 929-9090 | <input type="checkbox"/> <b>VOYER PHARMACY, MONTRÉAL</b><br>Tel.: 1 877 426-0406<br>Fax: 1 877 426-0546<br><a href="mailto:pharmacie.voyer.csi@ssss.gouv.qc.ca">pharmacie.voyer.csi@ssss.gouv.qc.ca</a> | <input type="checkbox"/> Kangiqsualujuaq 819 337-9090<br><input type="checkbox"/> Kuujuaq 819 964-2905<br><input type="checkbox"/> Aupaluk 819 491-9090<br><input type="checkbox"/> Kangirsuk 819 935-9090<br><input type="checkbox"/> Quaqtaq 819 492-9090<br><input type="checkbox"/> Kangiqsujuaq 819 338-9090<br><input type="checkbox"/> Tasiujaq 819 633-9090 | <input type="checkbox"/> <b>TULATTAVIK PHARMACY, KUJJUAQ</b><br>Tel.: 819 964-2905 # 201/277<br>Fax: 819 964-0035<br><a href="mailto:pharmacy.kuujuaq@ssss.gouv.qc.ca">pharmacy.kuujuaq@ssss.gouv.qc.ca</a> |
| <input type="checkbox"/> Puvirnituq 819 988-9090  | <input type="checkbox"/> <b>INUULITSIVIK PHARMACY, PUVIRNITUQ</b><br>Tel.: 819 988-2957 #263<br>Fax: 819 988-2551<br><a href="mailto:pharmacie.pov@ssss.gouv.qc.ca">pharmacie.pov@ssss.gouv.qc.ca</a>   |   |   |