



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

<b>Tuberculosis Program Medical Prescription</b>
<b>TREATMENT FOR LATENT TUBERCULOSIS INFECTION - ISONIAZID DIE</b>
Allergies: <input type="checkbox"/> None or specify: _____
<input type="checkbox"/> Pregnant: _____ weeks <input type="checkbox"/> Breast-feeding



**ADULT OR CHILD**

Date of prescription: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 YYYY-MM-DD

Weight: \_\_\_\_\_ kg

**Isoniazid (INH) DIE self-administered: 270 doses over 9 months**

- CHILD (under 15 years)  
 Isoniazid 10mg/kg (10 to 15 mg/kg) (max.: 300 mg), i.e.:  
 Pyridoxine (vit. B6) 1 mg/kg (max.: 25 mg), i.e.:
- ADULT (15 years and older)  
 Isoniazid 5 mg/kg (max.: 300 mg), i.e.:  
 Pyridoxine (vit. B6) 1 mg/kg (max.: 25 mg), i.e.:

**TO BE COMPLETED BY PHARMACY:**

\_\_\_\_\_ mg PO DIE x 270 doses

\_\_\_\_\_ mg PO DIE x 270 doses

\_\_\_\_\_ mg PO DIE x 270 doses

\_\_\_\_\_ mg PO DIE x 270 doses

Physician's signature: \_\_\_\_\_

Block letters: \_\_\_\_\_

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

<i>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.</i>			
<i>Check the village of origin and the pharmacy concerned:</i>			
<b>Inuulitsivik Health Centre</b>		<b>Ungava Tulattavik Health Centre</b>	
<input type="checkbox"/> Salluit 819 255-9090 <input type="checkbox"/> Ivujivik 819 922-9090 <input type="checkbox"/> Akulivik 819 496-9090 <input type="checkbox"/> Inukjuaq 819 254-9090 <input type="checkbox"/> Umiujaq 819 331-9090 <input type="checkbox"/> Kuujuaaraapik 819 929-9090	<input type="checkbox"/> <b>VOYER PHARMACY, MONTRÉAL</b> Tel.: 1 877 426-0406 Fax: 1 877 426-0546 <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 <input type="checkbox"/> Kuujuaq 819 964-2905 <input type="checkbox"/> Aupaluk 819 491-9090 <input type="checkbox"/> Kangirsuk 819 935-9090 <input type="checkbox"/> Quaqtaq 819 492-9090 <input type="checkbox"/> Kangiqsujuaq 819 338-9090 <input type="checkbox"/> Tasiujaq 819 633-9090	<input type="checkbox"/> <b>TULATTAVIK PHARMACY, KUJJJUAQ</b> Tel.: 819 964-2905 # 201/277 Fax: 819 964-0035 <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> Tel.: 819 988-2957 #263 Fax: 819 988-2551 <a href="mailto:pharmacie.pov@ssss.gouv.qc.ca">pharmacie.pov@ssss.gouv.qc.ca</a>		