



Centre de Santé et Services Sociaux Inuulitsivik
Inuulitsivik Health & Social Services Centre
 Puvirnituq, Québec J0M 1P0
 T 819 988-2957 / F 819 988-2796
 ᐅᓄᓄᓄ ᐅᓄᓄᓄ ᐅᓄᓄᓄ ᐅᓄᓄᓄ
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
TREATMENT FOR LATENT TUBERCULOSIS INFECTION - ISONIAZID DOT
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) DOT 2x/week, i.e., 78 doses over 9 months*

TO BE COMPLETED BY PHARMACY:

_____ mg PO 2x/week x 78 doses
 _____ mg PO 2x/ week x 78 doses
 _____ mg PO 2x/ week x 78 doses
 _____ mg PO 2x/ week x 78 doses

- CHILD (under 15 years)
 Isoniazid 20-30 mg/kg (max.: 900 mg), i.e.:
 Pyridoxine (vit. B6) 2 mg/kg (max.: 50 mg), i.e.:
- ADULT (15 years and older)
 Isoniazid 20-30 mg/kg (max.: 900 mg), i.e.:
 Pyridoxine (vit. B6) 2 mg/kg (max.: 50 mg), i.e.:

* 78 doses over 9 months to be administered under directly observed therapy (DOT) 2x/week.

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>			
Inuulitsivik Health Centre		Ungava Tulattavik Health Centre	
<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"/> VOYER PHARMACY, MONTRÉAL Tel.: 1 877 426-0406 Fax: 1 877 426-0546 pharmacie.voyer.csi@ssss.gouv.qc.ca	<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"/> TULATTAVIK PHARMACY, KUJJJUAQ Tel.: 819 964-2905 # 201/277 Fax: 819 964-0035 pharmacy.kuujuaq@ssss.gouv.qc.ca
<input type="checkbox"/> Puvirnituq 819 988-9090	<input type="checkbox"/> INUULITSIVIK PHARMACY, PUVIRNITUQ Tel.: 819 988-2957 #263 Fax: 819 988-2551 pharmacie.pov@ssss.gouv.qc.ca		