NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services

Latent Tuberculosis Infection LTBI Medication Case Management Form

(Retain this form on Patient chart and use for prescription refills)

Prescriber Information

Last Name	First	Middle

Street Address or P.O. Box	Phone No. (with area code)	Fax No. (with area code)

City	State	Zip

Patient Information

Patient's Last Name	First	Middle

Street Address or P.O. Box	☐ Immigrant ☐ Refugee	Contact No. (with area code)

City	State	Zip	County of Residence	Birthdate	Age	Sex ☐ M ☐ F

Race
☐ White
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ Unknown

Ethnicity
☐ Hispanic
☐ Non-Hispanic

Country of Birth	Language spoken at home

Contact to an active case of TB? ☐ Yes ☐ No	Insurance / Medicaid ☐ Yes ☐ No

TB Medicine Prescription and Dispensing Information

Prescription #1

INH300mg #90 (3 bottles, 30/bottle) Sig: 1po/day Date:_____ Signature_____
Pyridoxine 50mg (VitB6) #100 (1 bottle) Sig: 1po/day Date:_____ Signature_____
Medicine pick-up: Date_____ # of bottles of INH dispensed: ☐ 1 ☐ 2 ☐ 3
Medicine pick-up: Date_____ # of bottles of INH dispensed: ☐ 1 ☐ 2
Medicine pick-up: Date_____ # of bottles of INH dispensed: ☐ 1

Prescription #2

INH300mg #90 (3 bottles, 30/bottle) Sig: 1po/day Date:_____ Signature_____
Pyridoxine 50mg (VitB6) #100 (1 bottle) Sig: 1po/day Date:_____ Signature_____
Medicine pick-up: Date_____ # of bottles of INH dispensed: ☐ 1 ☐ 2 ☐ 3
Medicine pick-up: Date_____ # of bottles of INH dispensed: ☐ 1 ☐ 2
Medicine pick-up: Date_____ # of bottles of INH dispensed: ☐ 1

Prescription #3

INH300mg #90 (3 bottles, 30/bottle) Sig: 1po/day Date:_____ Signature_____
Pyridoxine 50mg (VitB6) #100 (1 bottle) Sig: 1po/day Date:_____ Signature_____
Medicine pick-up: Date_____ # of bottles of INH dispensed: ☐ 1 ☐ 2 ☐ 3
Medicine pick-up: Date_____ # of bottles of INH dispensed: ☐ 1 ☐ 2
Medicine pick-up: Date_____ # of bottles of INH dispensed: ☐ 1

Therapy Ended (Month, Day, Year)

Note: If INH 100 mg or Rifampin is required, please contact the program manager.

Please send this form to:
State of Nebraska, PO Box 95026, Lincoln, NE 68509, Attn: TB Program Manager / Fax: (402) 742-8359

Barb Koester
TB Program Manager
(402) 471-6441

Kristin Gall/RN
Program Specialist
(402) 471-1372

Ashleigh McCormick
Secretary II
(402) 471-0360