

ATTENTION” ---Important notice! Please read and respond

RE:

(LAST)

(FIRST)

(Middle)

(DOB)

Please complete the box below and fax to **651-201-5500** as soon as possible after your patient starts to take this medication. **If we do not receive confirmation from you that the patient has begun to take this medication, we will not send any refills.**

****Note**** First refill will be sent through UPS 21 days after start date.
Subsequent refills will be sent every 28 days until completion.

If the patient treatment is interrupted early for any reason, notify MDH as soon as possible to hold or stop unnecessary shipments.

LTBI MEDICATION START DATE VERIFICATION FORM

- Patient received and began taking medication. (DO NOT POST DATE)
Date medication started: _____/_____/_____
- Patient already began treatment with medication obtained from another source.
Please provide date patient began to use medication **supplied by the Minnesota Department of Health:** _____/_____/_____
- Patient NEVER started treatment

Agency/clinic: _____ Telephone no. (____)_____

Your name: _____

Important recommendations regarding pre-treatment evaluation and monitoring during therapy (including a suggested monitoring tool) are available at www.health.state.mn.us/tb (click on “TB Guidelines and Recommendations” then “Targeted TB Testing and Treatment of Latent TB Infection”) or call the number below.

Thank you for your cooperation.

**Fax to: Lenette Bauer, TB Medications Coordinator
Minnesota Dept. of Health
651-201-5506
FAX: 651-201-5500**



Tuberculosis Prevention & Control