## Mycobacterium tuberculosis (TB) Medication Dispensing Report

Pursuant to <u>NAC 441A</u> this form may be used whenever a registered pharmacist or intern pharmacist dispenses two or more prescription drugs used for the treatment of TB requiring them to report to the Local Health Authority. As a provider you are authorized, under HIPAA Section <u>164.512b</u> "Disclosures for Public Health Activities", to release protected health information without patient consent to ensure public health and safety.



## **TB DRUG DISPENSING REPORT**

	NAME OF PHARMACY:			
FACILITY REPORTING	ADDRESS OF PHARMACY:			
	NAME OF PHARMACIST OF	INTERN PHARMACIST:	IACIST: PHONE NUMBER:	
	FIRST NAME LA DATE PRESCRIPTION FILLEE	AST NAME D: : MONTH DAY YEAR MILITARY TIME		
	DATE AND TIME THE LOCA	L HEALTH AUTHORITY WAS NOTIFIED: MC	: DNTH DAY YEAR MILITARY TIME	
	NAME OF PRESCRIBING HEALTH CARE PROVIDER:			
PROVIDER INFORMATION	FIRST NAME	LAST NAME		
	PHONE NUMBER:		DATE PRESCRIPTION WRITTEN: MONTH DAY YEAR	
	ADDRESS:			
	COMMENTS:			
PATIENT INFORMATION	PATIENT NAME:			
	FIRST NAME	LAST NAME		
	ADDRESS:		DATE OF BIRTH: MONTH DAY YEAR	
	CITY:	STATE:		
	PHONE NUMBER:			
	COMMENTS:			
Check All That Apply				
Only report if two or more boxes are checked and a report has not previously been submitted for this person				
MEDICATION DISPENSE	Ethambutol	Pyrazinamide	Rifampin	
	🗌 Isoniazid	Streptomycin	Rifabutin	
	Other:			
FAX COMPLETED FORMS TO YOUR LOCAL HEALTH AUTHORITY AT:				
	(	CARSON CITY: (775) 887-2138 CLARK COUNTY: (702) 759-1414	WASHOE COUNTY: (775) 328-3764 REST OF STATE: (775) 684-5999	