



Wyoming Department of Health
Tuberculosis Program
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TB Program Patient Medication List

Today's date: _____ Patient's date of birth: _____

Patient's last name: _____ First name: _____

Allergies: _____

This patient has been diagnosed with: ☐ Latent TB ☐ Active TB

TB Medications	Strength	Dose	Route	Frequency	Start Date	Stop Date	Prescriber
Ethambutol (EMB)							
Isoniazid (INH)							
Rifampin (RIF)							
Rifapentine (RPT)							
Moxifloxacin (MOX)							
Pyrazinamide (PZA)							
Pyridoxine (Vit B6)							

Other Medications

List all additional medications, including OTCs and herbs, that the client is taking. Check each medication for interaction with TB medications. Review the medication list with the client at each monthly assessment.

Medication	Strength	Dose	Route	Frequency	Potential Interaction	Prescriber
					Y <input type="checkbox"/> N <input type="checkbox"/>	
					Y <input type="checkbox"/> N <input type="checkbox"/>	
					Y <input type="checkbox"/> N <input type="checkbox"/>	
					Y <input type="checkbox"/> N <input type="checkbox"/>	
					Y <input type="checkbox"/> N <input type="checkbox"/>	
					Y <input type="checkbox"/> N <input type="checkbox"/>	
					Y <input type="checkbox"/> N <input type="checkbox"/>	
					Y <input type="checkbox"/> N <input type="checkbox"/>	
					Y <input type="checkbox"/> N <input type="checkbox"/>	
					Y <input type="checkbox"/> N <input type="checkbox"/>	

Signature of TB Case Manager: _____ Date: _____