Request for Second Line Anti-Tuberculosis Medications Form

Ship To:
Name:
Address:

Contact Person:
Email Address:

Kansas TB Control and Prevention Program

PLEASE PRINT CLEARLY

Patient Investigation or Case #	DOB	Medication	Dosage	Quantity	Lot #	Prescription #	Comment	KDHE Use Only

MEDICATIONS WILL BE LIMITED TO ATS/CDC RECOMMENDED TREATMENT REGIMES

Please fax form(s) to 785-559-4224

Clear

11/09/2021