



REQUEST FOR TB MEDICATION, TESTING SOLUTION & PRINTED MATERIAL
NORTH DAKOTA DEPARTMENT OF HEALTH

SFN 51154 (rev. 2/2012)

Report positive skin-test reactions to the North Dakota Department of Health using the Tuberculin Test Registration card. The Centers for Disease Control & Prevention recommends that people with latent TB infection be treated. Refer clients with positive reactions to their physician for evaluation, chest x-ray and a prescription for medication. Your local public health unit will monitor treatment and dispense free medications provided by the North Dakota Department of Health.

The Division of Disease Control maintains a database of positive reactors. If you want to know if a client has been a previous positive reactor and/or has completed treatment for latent TB infection, please call the Division of Disease Control for assistance at (701) 328.2376 or 1.800.472.2180.

PPD solution is shipped only on Monday and Wednesday if outdoor temperatures are suitable. Please fax your order to (701) 328-2499, or mail to TB Program, Division of Disease Control, 2635 East Main Avenue, Bismarck, N.D. 58501.

Styrofoam coolers are property of N.D. Department of Health and must be returned within 30 days. Return postage is not provided by the Department of Health.

Skin-Testing Solution	Qty. of Vials Ordered	Qty. of Vials Sent	Lot #	Exp. Date	Date Sent
PPD 1 ml vial (10 doses)					

Complete the section below or your order will not be shipped.

Check all that apply. Your facility is classified as:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Ambulatory surgical center | <input type="checkbox"/> Disabilities care | <input type="checkbox"/> ICF/MR | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Assisted living | <input type="checkbox"/> Public health unit | <input type="checkbox"/> Kidney dialysis | <input type="checkbox"/> Rehabilitation facility |
| <input type="checkbox"/> Basic care | <input type="checkbox"/> Home care for seniors | <input type="checkbox"/> Memory care/Alzheimer's | <input type="checkbox"/> Senior living community |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Home health care | <input type="checkbox"/> Mental health | <input type="checkbox"/> Skilled nursing facility |
| <input type="checkbox"/> Clinic | <input type="checkbox"/> Hospital | <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Substance abuse treatment |
| <input type="checkbox"/> College/university/school | <input type="checkbox"/> Human service center | <input type="checkbox"/> Rehabilitation, outpatient | <input type="checkbox"/> Transitional care |
| <input type="checkbox"/> Correctional/jail | <input type="checkbox"/> Other (please explain): | | |

Indicate who you will skin-test. Check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Employees, annual screening | <input type="checkbox"/> Inpatient annual screening |
| <input type="checkbox"/> Employees, pre-employment | <input type="checkbox"/> Patient, new admit |
| <input type="checkbox"/> Foreign-born person(s) | <input type="checkbox"/> Student, physician |
| <input type="checkbox"/> Homeless person(s) | <input type="checkbox"/> Student, RN, LPN, physician assistant |
| <input type="checkbox"/> Incarcerated person(s) | <input type="checkbox"/> Student, nurse aide |
| <input type="checkbox"/> Injecting drug user(s) | |

Effective July 1, 2011, PPD will not be provided for occupational health testing.

Send PPD to:

Attn.		
Facility		
Address (No PO Boxes- Street Address Only)		
Address		
City	ND	Zip

Name of Person Submitting Order
Telephone No.
Email Address
Date Ordered
Requested Delivery Date (allow 1 week)



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Medication	Qty. of Bottles Ordered	For State Use Only			
		Qty. of Bottles Sent	Lot #	Exp. Date	Date Sent
B ₆ (pyridoxine) 25 mg (100 tablets)					
B ₆ (pyridoxine) 50 mg (100 tablets)					
EMB (ethambutol/myambutol) 100 mg (100 tabs)					
EMB 400 mg (100 tablets)					
INH 100 MG (100 tabs)					
INH 300 mg (30 tablets)					
INH 300 mg (30 tablets)					
INH syrup, pint (473 ml), with spoons					
PZA (pyrazinamide) 500 mg (100 tablets)					
RIF (rifampin) 150 mg (30 tabs)					
RIF (rifampin) 300 mg (60 capsules)					

TB medications are shipped Monday through Friday. Please fax to (701) 328.2499, or mail to:

RJ Jansen
 Division of Disease Control
 N.D. Department of Health
 2635 East Main Avenue
 P.O. Box 5520
 Bismarck, N.D. 58506-5520

If you have questions, call 1.800.472.2180 or 701.328.2376.

Send TB Meds to:

Attn.		
Facility		
Address (No PO Boxes- Street Address Only)		
Address		
City	ND	Zip

Name of Person Submitting Order
Telephone No.
Email Address
Date Ordered
Requested Delivery Date



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Printed Material from Centers for Disease Control and Prevention		Qty.
A limited supply of CDC materials is kept in the Division of Disease Control. CDC's order form is located at http://wwwn.cdc.gov/pubs/tb.aspx . Ordering directly from CDC may result in a quicker delivery to you and many items may be printed and reproduced. Visit their website to view items not listed here.		
1.	Get the Facts About TB Disease	
2.	Guide for Primary Health Care Providers: Targeted Tuberculin Testing and Treatment of Latent TB Infection	
3.	Induration Rulers	
4.	Protect Your Family and Friends from TB: The TB Contact Investigation	
5.	Skin-Test Posters	
6.	Skin-Test Training DVD	
7.	Staying on Track With TB Medicine	
8.	Take Steps to Control TB When You Have HIV	
9.	Questions and Answers About TB (for the client)	
10.	What You Need to Know About TB Infection	
11.	What You Need to Know About the TB Skin Test	

Forms from Division of Disease Control, N.D. Department of Health		Qty.
Visit our website at http://www.ndhealth.gov/		
1.	INH Side Affects Checklist, SFN 14535	
2.	Treatment of LTBI, SFN 50250, (3-part carbon form for reporting treatment to NDDoH)	
3.	Tuberculin Test Registration cards (SFN 7722)	
4.	TB Contact Screening of Active Cases (SFN 53161)	
5.	Latent TB Infection – Directly Observed Treatment (SFN 54414)	
6.	TB Disease – Directly Observed Treatment (SFN 54413)	

Comments?

Send Printed Materials to:

Attn:		
Facility		
Address		
Address		
City	ND	Zip

Name of Person Submitting Order
Date Ordered
Requested Delivery Date (allow 1 week)
Telephone No.
Email Address