PAC Action Request

(Required) Fill out header with information regarding the person reaching out to PAC

Name:_____

Title:_____

Email:_____

Phone:_____

Call, Email or Fax this form to the Patient Advocacy Coordinator (PAC):

Heather Manrique, 337-303-5167, heather.manrique@la.gov, Fax 337-262-1326

Note: As long as LATB[1] is up to date with meds, labs, notes, etc. then only the highlighted/(Required) areas need to be filled out before submitting to PAC.

(Required)

Region: _____ Patient Name: _____

DOB: ____-____-____ LATB#: _____

Treatment Data Treatment Start Date: ____-____-____

Check ✔ Box for Current Regimen (Medication/Dose): INH/____ RIF/____ PZA/____

EMB/____ B6/____ MO/____ Other: ____/____ ____/____ ____/____

Daily____ Biweekly____ Triweekly____

Current AFB Smear: 1+___ 2+____3+____4+____Negative____

Allergies: Y or N Resistance: Y or N Side Effects: Y or N

If yes, explain:_____

(Required)	**Below to be filled out by reporting person before sending to PAC**
Reported Issue:	
Methods attempted:	
Known Barriers:	
Suggestions:	

[1]If LATB is not up to date then Treatment Data must be filled out before submitting to PAC.