

Vital Health Pharmacy & Medical IV Clinic #3
1990 Fort Street, Victoria, BC, V8R 6V4 (Fort & Foul Bay)
Fax: 778-247-2309
Phone: 778-400-7900

IV Infusion or Injection
REFERRAL FORM

Patient Label	
(Name)	_____
(PHN)	_____
(DOB)	_____
(Phone)	_____
(Address)	_____

Today's date _____/_____/_____

Patient status, including known allergies:

Instructions prior to treatment:

Prescription:

Repeats X _____ Frequency _____

Route of Administration : IV ___ IM ___ SC ___

MD Signature

License # (print clearly)

MD Name (Please print)

MD Fax #

MD Phone #

For administration at :

Vital Health Pharmacy & Medical IV Clinic - Suite 102, 1990 Fort St. Victoria (Fort and Foul Bay)

Other location: _____

Target date for first Injection / Infusion: _____

Other Instructions / notes:

SEND BY FAX TO VITAL HEALTH PHARMACY #3 (Fort & Foul Bay)

778-247-2309

THE RECEIVED COPY WILL BE THE ORIGINAL PRESCRIPTION