Vital Health Pharmacy & Medical IV Clinic #2
560 West Ave., Kelowna, BC, V1Y 4Z4
Fax: 778-738-3196
Phone: 778-738-3195

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

IV Infusion or Injection REFERRAL FORM

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 560 West Avenue, Kelowna**

□ **Other location:** _____

Target date for first Injection / Infusion: _____

Other Instructions / notes:

_____
_____
_____
_____

SEND BY FAX TO VITAL HEALTH PHARMACY AT 778-738-3196
THE RECEIVED COPY WILL BE THE ORIGINAL PRESCRIPTION