Medical Daycare Booking Requests / Orders (Excludes Blood Products)
Please FAX to 250-370-8978

Patient Last Name, First & Middle	
PHN or Other Insurer	Preferred Name
DOB (dd-mm--yyyy)	Gender ☐ F ☐ M
Address (Street, City, Province, Postal Code)	
Primary Telephone	Family Physician
Diagnosis	Please update MOST in Powerchart, as required

Physician Orders ☐ Recurring Encounter (Maximum 6 month duration) ☐ See attached	**URGENCY** Urgent (within week): ☐ Semi-Urgent (within month): ☐ Elective (4 – 6 weeks): ☐

Significant Medical History which may impact on proposed treatment or procedure	☐ PICC ☐ SVAD ☐ Pregnant ☐ Caregiver Needed ☐ See attached
Allergies/Sensitivities ☐ None ☐ See attached	Medications ☐ None ☐ See attached

Ordering Physician________________________ Contact Number____________________ MSP# _______________
(Please Print)
Physician Signature________________________ Date: __________________
(dd-mm--yyyy)

MEDICAL DAYCARE BOOKING OFFICE USE ONLY