

**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 <input type="checkbox"/> F <input type="checkbox"/> M
Address (Street, City, Province, Postal Code)	
Primary Telephone	Family Physician
Diagnosis	MOST (Medical Orders for Scope of Treatment) <input type="checkbox"/> See attached Please send the most recent MOST if completed <a href="#">Medical Orders for Scope of Treatment (MOST)</a>
Physician Orders <input type="checkbox"/> Recurring Encounter (Maximum 6 month duration) <input type="checkbox"/> See attached	
Significant Medical History which may impact on proposed treatment or procedure <input type="checkbox"/> PICC <input type="checkbox"/> SVAD <input type="checkbox"/> Pregnant <input type="checkbox"/> Caregiver Needed <input type="checkbox"/> See attached	
Allergies/Sensitivities <input type="checkbox"/> None <input type="checkbox"/> See attached	Medications <input type="checkbox"/> None <input type="checkbox"/> See attached
Ordering Physician _____ (Please Print)	Contact Number _____ MSP# _____
Physician Signature _____	Date: _____ (dd-mm-yyyy)
<b>MEDICAL DAYCARE BOOKING OFFICE USE ONLY</b>	
Appointment Dates/Times	
Patient Notified <input type="checkbox"/> Yes	Expiration Date of Recurring Encounter (dd-mm-yyyy)