island health
SOUTH ISLAND

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	MOST (Medical Orders for Scope of Treatment) ☐ See attached Please send the most recent MOST **if completed** Medical Orders for Scope of Treatment (MOST)

Physician Orders ☐ Recurring Encounter (Maximum 6 month duration) ☐ See attached

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 _____ (Please Print) Contact Number _____ MSP# _____

Physician Signature _____ Date: _____ (dd-mm--yyyy)

MEDICAL DAYCARE BOOKING OFFICE USE ONLY

Appointment Dates/Times

Patient Notified ☐ Yes Expiration Date of Recurring Encounter (dd-mm--yyyy)