ECHO
HEALTH

210-1964 Fort Street
Victoria, B.C., V8R 6R3
Phone: 250- 419- 8344
Fax: 250- 419- 8344

ECHO HEALTH IV INFUSION REQUISITION

Today's date: ________/_________/_________

Patient Name: _______________________________ **PHN#:**_____________________________
Patient DOB: _______________________________
Patient Phone #: ______________________________ **Patient Email:** _____________________

Patient status (if relevant):
____
____

Instructions prior to treatment (if any) :
____
____

Prescription: ____

Repeats X ________ **Frequency** _____________ **Route of Administration :** IV ___

____ ________________________
MD Signature **License #**

____ ______________ ________________
MD Name (Please print) **MD Fax #** **MD Phone #**

For Injection at : Echo Health Infusion Clinic

Target date for first Injection / Infusion: _________________________

Other Instructions / notes:

Pharmacy Preference:

☐ Free Delivery to Echo Health

*Please **Fax** this **form** to Cridge Pharmacy 2 in addition to Echo Health,*

Cridge Pharmacy Contact:
***Fax: 1-855-297-5608** Phone: 250-652-8880*

☐ Patient will arrange medication and bring to appointment
**Please specify pharmacy*

*Contact Details:*________________

*Fax/Phone:*___________________