



FAX

Public Health Services – Reproductive Supplies Form

TO/DESTINATAIRE :

FROM/EXPÉDITEUR :

FAX # :

DATE :

PAGE(s) :

SUBJECT/OBJET : **Reproductive Supplies Prescription Request**

<p>Fill in all fields below or this request is invalid.</p> <p>PHN/NP Name: _____</p> <p>Office Phone #: _____</p> <p>Office Location: _____</p> <p>GL Code: <u>880-1-715521211-46370</u></p> <p>Courier Delivery Site (if different from Office Location): _____</p> <p>Client's Name: _____</p> <p>PHIN: _____</p> <p>Birth Date: _____</p> <p>Prescriber's Name: _____</p> <p>Prescriber's Phone #: _____</p> <p>Prescriber's Fax #: _____</p>	<p>Starter pack (1 only) given at Public Health Office: (check) YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p><input type="checkbox"/> For MIRENA, KYLEENA, COPPER IUD (Mona Lisa, Liberte, FlexiT), HALOETTE, EVRA PATCH or Lolo please check box to indicate client has been assessed, meets criteria for public health contraceptive program, and a formulary product is <u>not</u> an option. For IUD/IUS: Number of vaginal births _____</p> <div style="text-align: center; padding: 50px 0;"> <p>Attach Prescription Here</p> </div>
<p>Public Health Office Use Only:</p> <p>Date Rx Received: _____</p> <p>Quantity Sent: _____</p> <p>Date Rx Filled: _____</p>	<p>Pharmacy Use Only: Lot #: _____ Expiry Date: _____</p>