RSV Program – Authorization for Treatment Form

Provincial Health Services Authority
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Patient Name: _____ **DOB (dd/mmm/yyyy):** _____

Prov. Health #: _____ **Registration #:** _____

Parent / Legal Guardian Name (Print): _____

Phone: _____ **Other Phone / Contact:** _____

Authorization for Administration of Palivizumab and Follow-Up

The benefits and risks of this medication have been explained to me and I have received information on reducing the risk of respiratory infections. I consent to my child receiving Palivizumab as per the BC RSV Immunoprophylaxis Program Guidelines and to contact for follow-up.

Signature of Parent/Guardian: _____ **Date:** _____

This section for Physician/Nurse providing care

The application form's details and contact information have been confirmed above and the patient is eligible for funded prophylaxis. I have provided information on the RSV program and have answered questions. I confirm that consent for treatment and follow-up has been obtained *(telephone consent is acceptable)*.

_____ Signature of Physician/Nurse obtaining consent

_____ Signed on [this date]: [dd/mmm/yyyy]

_____ Printed name of Physician/Nurse

_____ Contact telephone number of Physician/Nurse