# 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:** _____

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**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)*.

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| Signature of Physician/Nurse obtaining consent | Signed on [this date]: [dd/mmm/yyyy] |
| Printed name of Physician/Nurse | Contact telephone number of Physician/Nurse |