



Cook's Pharmacy

PROUDLY INDEPENDENT

Administration of Medication by Injection - Referral Form

Date: _____

Patient:

Last Name:	First Name:
OHIP:	DOB:

Physician:

	CPSO:
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Injection:

Drug:	Dose:	Route:
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Directions:

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Interval (if applicable):

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Next Scheduled Injection Due Date: _____

Cooks Pharmacy
102, 182 Pinebush Road
Cambridge ON, N1R 8J8

Phone: 548-288-4088
Fax: 1-888-999-4831

101-520 University Ave West
Waterloo, ON