

AccessLink Botox Prescription Form

Patient Information

Name: _____ **DOB (DD/MM/YYYY):** ____/____/____ **PHN:** _____

Address: _____ **Allergies:** _____

Home #: _____ **Cell #:** _____ **Email:** _____

Insurance Name: _____ **Group ID:** _____ **Certificate ID:** _____

Patient to be initially contacted via: ☐ call ☐ email **Best time to reach patient:** ☐ morning ☐ afternoon ☐ evening

Patient has consented to AccessLink's receipt, use and disclosure of their personal information for the purpose of i) drug reimbursement, ii) pharmacy, iii) clinical services

Verbal Consent Received by: _____ Date of consent: _____

Prescription

BOTOX THERAPEUTIC (Botulinum Toxin type A)

For Injection at an interval as directed by the physician

Quantity: _____ (50 units per vial) **Indication:** ☐ Overactive Bladder

_____ (100 units per vial) ☐ Neurogenic Detrusor Overactivity

_____ (200 units per vial) Due to: ☐ MS OR ☐ Spinal Cord Injury

Repeats: _____ AND

☐ Failed to respond to behavioural modifications

☐ Other: _____

List or attach any previously tried medications (dose, duration, outcome):

Shipping Information

Deliver to office:

☐ Next Appointment Date: _____

Prescriber Info and Authorization

Clinic Contact: _____ **Address:** _____

Phone: _____ **Fax:** _____ **Email:** _____

Prescriber Name: _____ **License #:** _____

Prescriber Signature: _____ **Date:** _____