BC CANCER
Provincial Health Services Authority

**Send completed form to FAX №: (604) 708-2026**
**Inquiries email: cap_bcca@bccancer.bc.ca**

# UNDESIGNATED INDICATIONS REQUEST FORM

***BC CANCER COMPASSIONATE ACCESS PROGRAM – SEE CAP PROCESS***

********** Please fill in this section for review **********

DATE: D _____ M _____ Y _____ ☐ Mark as clinically urgent

**REQUESTING PHYSICIAN**: _____ Phone: _____

MSC#: _____ **Fax**: _____

Medication dispensing at CSI ☐ FVC ☐ VC ☐ VIC ☐ AC ☐ or Communities Oncology Centre: _____

**PATIENT NAME**: _____ **BCCA №**: _____

BIRTHDATE: D _____ M _____ Y _____ **Diagnosis**: _____

Clinical information:

Past treatment (drugs, dates):

Rationale (references):

Required eligibility criteria values (if applicable):

| **Drug(s) or Protocol** | **Dose, Schedule and # of Cycles** |
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