Provincial Drug Programs
P. O. Box 2000
Charlottetown PE C1A 7N8

TRANSPLANT DRUG PROGRAM

CLIENT REGISTRATION

Please complete this form in full.

Name (last name, first name, middle initial)		
Provincial Health Number	**Date of Birth** (day, month, year)	**Sex:** Male ☐ Female ☐
Mailing Address	**City or Town**	**Postal Code**
Home Phone Number:	**Work Phone Number:**	
Allergies		
Medical Conditions		
This patient has had the following organ transplant:		
Physician's Name & Signature: **(PRINT NAME & SIGN)**		**Date:**
Mailing Address	**City or Town**	**Postal Code**
Telephone & Fax Nos.		

Note:
The PEI Drug Programs requires that prescriptions are received at least three (3) working days before the client needs them.

Please submit this form to:

PEI Provincial Pharmacy
Attention: Transplant Program
P.O. Box 2000, 16 Fitzroy St.
Charlottetown, PE C1A 7N8

Telephone: **1-902-368-4904**
Fax: **1-902-368-5001**

April 2018/CMC