2011 Compassionate Contraceptive Assistance Program - **Request Form**

THE SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS OF CANADA
780 promenade Echo Drive, Ottawa, Ontario K1S 5R7
Tel/Tél.: 1 800 561-2416 or/ou (613) 730-4192
Fax/Téléc.: (613) 730-4314 **www.sogc.org**

All information requested must be completed in order to process this request.

* Note:
- A tracking number will be assigned and emailed to you by the SOGC upon confirmation of your order.
- Contact the SOGC if you have not received a confirmation of your order within two business days.
- Allow 4-6 weeks for product delivery.
- The Compassionate Contraceptive Assistance Program provides free prescriptions for the specified duration to patients whose financial hardship becomes a barrier to obtaining contraceptives. You may re-submit another application following this period should your patient continue to meet the Program's criteria.

Prescribing Physician Information (Please print, type or stamp.)

Name: ______________________________

Office/Clinic Name: ______________________________

Office/Clinic Address: ______________________________

City: ______________________ Province: __________ Postal Code: __________

Tel: ______________________ Fax: ______________________

E-mail address (required to receive tracking number): ______________________

Please indicate **office/clinic hours for delivery purposes:** ______________________

Dosing Information

- ❍ **Alesse** - 28-day - 6 months
- ❍ **Marvelon** - 21-day - 6 months
- ❍ **Tri-Cyclen Lo** - 21-day - 6 months
- ❍ **Tri-Cyclen Lo** - 28-day - 6 months
- ❍ **Yasmin** - 28-day - 6 months
- ❍ **YAZ 24/4 day** - 28-day - 6 months
- ❍ **EVRA Transdermal Contraceptive Patch** - 3 months
- ❍ **NuvaRing Vaginal Contraceptive Ring** *(cold chain broken)* - 2 months

❍ To the best of my knowledge this patient, for whom this request is submitted, is not covered by a drug reimbursement plan and cannot afford the medication and/or insurance co-payment fee. This program is for compassionate use only.

Physician's Signature: ______________________ License Number: ______________________

Physician's Printed Name: ______________________ Date: ______________________

Suggestions or Comments: ______________________________

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Tracking number assigned by the SOGC: ______________________________

FOR PHYSICIAN'S OFFICE USE ONLY

Please complete and save this portion for your office file AFTER you fax the form to toll-free number 1-866-888-7455.

Patient's Name: ______________________________

Date of Birth: ______________________ File Number: ______________________