ZOLEDRONIC ACID INFUSION ORDER FORM

Patient Information:

Patient name:	DOB (dd/mm/yyyy):	Address:	Weight:
Patient ID:	Allergies:	Phone number:	Labs: GFR/Creatinine

Physician Information:

Physician name:	Phone number:	Fax number:

Prescription:

Zoledronic Acid to be administered by IV infusion as per product monograph

Dose: ☐ 5 mg in 100 mL ☐ 4 mg in 5 mL (Concentrate)

Number of doses: _____ Interval: ☐ Monthly, ☐ Annually

Indication: _____

Infusion to be provided at: _____

☐ **SRx Clinics:** SRx will arrange infusion appointment
☐ **Hospital Day Medicine:** Prescriber to arrange infusion appointment

If the patient has a history of reaction:	**If the patient has adverse reaction DURING/POST infusion:**
Give: ☐ Methylprednisolone 125mg IV x1 ☐ Diphenhydramine 25-50 mg PO/IV ☐ Acetaminophen 650 mg PO ☐Other_____	**Give:** ☐ Hydrocortisone 100mg IV ☐ Diphenhydramine 25-50 mg PO/IV ☐ Acetaminophen 650 mg PO ☐ Dimenhydrinate (Gravol©) 25-50 mg PO/IV

Prescriber signature: _____ **Date:** _____

PLEASE FAX COMPLETED FORM TO 587-454-0885

Patients will be scheduled at an SRx Clinic within 7 days of the pharmacy having received payment. Prescriber will be provided with post infusion report once infusion has taken place. Prescriber will be notified if SRx is unable to reach patient, or patient elects to not proceed with infusion. For patients booked at Hospital Day Medicine, Drug will be delivered to patients' home; It is the responsibility of patient to take drug to their appointment. Bloodwork may be re-ordered to meet the current standards of the Clinic.

SRx CLINICS