Order to Infuse – Zoledronic Acid

PerCuro by sentrex

t: 250-382-6270 | f: 250-382-6273

PATIENT PROFILE

Last Name: _____ First Name: _____

Phone: _____ Alternate: _____

DOB: (dd-mmm-yyyy) _____ PHN: _____ Sex: ○ Female ○ Male ○ Other

Number of prior Zoledronic Acid Infusions: _____ Patient medically cleared to proceed with infusion on or after: (dd-mmm-yyyy) _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Caregiver Name (if applicable): _____ Caregiver Phone: _____

PHYSICIAN INFORMATION

Prescription for Zoledronic Acid: 5 mg / 100 mL Vial

PHYSICIAN STAMP

Please check use:

- ○ Treatment of postmenopausal osteoporosis
- ○ Prevention of postmenopausal osteoporosis in women with osteopenia
- ○ To increase bone mineral density (BMD) in men with osteoporosis
- ○ Treatment of glucocorticoid-induced osteoporosis (GIO)
- ○ Paget's disease

Last Name: _____ First Name: _____

Phone: _____ Fax: _____

I certify that this prescription is an original prescription and will not be reused.

Physician Signature: _____ Date: (dd-mmm-yyyy) _____

**Effective date, order expires one year from date of signature.*

Additional Physician Comments:

○ Rx Given to Patient