CALGARY WEST MEDICAL INFUSIONS

Calgary West Medical Infusions
1107 - 37 Street SW (Upper Level)
Calgary, AB, T3C 1S6

PHONE: 403 300 8882
FAX: 403 648 1898
EMAIL: contact@calgarywestmedicalinfusions.com
WEB: calgarywestmedicalinfusions.com

ORDER FORM: Zoledronic Acid IV Infusion

Patient Information

First Name: _____ Last Name: _____

PHN: _____ DOB: (YYYY-MM-DD) _____

Sex: _____ Address: _____

Phone: _____ Email: _____

Order

☐ Zoledronic Acid 5mg as single dose per year (Dr Reddy's brand only)

☐ Forward any attached prescription to the patient's preferred pharmacy

Nursing Orders: Dilute and infuse zoledronic acid as per drug monograph over 30 minutes and provide any PRN or emergency medications or oxygen as may be required while responding to an infusion reaction or in case of an emergency.

Special Instructions or comments: _____

_____

_____

Prescribing Physician

Name: _____

Signature: _____ Date: _____

Clinic: _____

Phone: _____ Fax: _____

Co-ordinating Pharmacy (Optional)

Pharmacy name: _____ Fax: _____

Office Use Only

Eligibility Check for Zoledronic Acid Infusion:

No known bisphosphonate allergy:	Y ☐	N ☐
eGFR ≥ 35 mL/min/1.73 m^2:	Y ☐	N ☐
Calcium 2.1–2.6 mmol/L:	Y ☐	N ☐
25-OH Vitamin D ≥ 50 nmol/L :	Y ☐	N ☐

Booking information:

Appt Date: _____ Appt Time: _____

First Infusion Y ☐ N ☐ Date of last infusion: _____

FAX TO: 403-648-1898 (Calgary West Medical Infusions)