SANDSTONE INFUSION CLINIC
Glenmore Landing
Building D, Suite D274 1600 90 Ave SW Calgary T2V 5A8
P: (403) 255-4200 ext. 7 F: (403) 236-0846
GLInfusionClinic@nbly.ca

Zoledronic Acid IV Infusion Order Form

Name:
DOB: (MM/DD/YYYY)
PHN:
Ph#:

Diagnosis: Choose 1	**Other info:**
☐ Postmenopausal osteoporosis ☐ Glucocorticoid-induced osteoporosis ☐ Paget's disease ▶ alkaline phosphatase (ALP): _____ U/L test date: _____ ☐ Other: _____	Height: _____ Weight: _____ Fracture risk: _____ CrCl: _____ mL/min

Confirm: treatment appropriate to initiate now

Contraindications:

Patient's CrCl is >35 mL/min. ☐ No (contraindicated as per monograph, but will be evaluated on individual circumstance) ☐ Yes

Is the patient's renal function acutely impaired? ☐ No ☐ Yes *(contraindicated)*

Is the patient currently pregnant and/or breastfeeding? ☐ No ☐ Yes *(contraindicated)*

Is the patient hypocalcemic?

☐ No ▶ Serum calcium: _____ mmoL/L test date: _____ ☐ Yes *(contraindicated)*

▶ Vitamin D (25-Hydroxy): _____ nmoL/L test date: _____

Does the patient have any allergies? ☐ No ☐ Yes ▶ List all allergies and reactions:

Has the patient ever had a reaction to a bisphosphonate before?

☐ No ☐ Yes *(contraindicated if hypersensitive)* ▶ List all products and reactions:

Considerations for delaying treatment:

- unhealed open, oral lesions
- unresolved ONJ risk factors
- routine oral exam required
- suspected atypical fracture
- opthalmologic disturbance
- bisphosphonate drug holiday

Order	**Education by Prescriber**
Choose 1: ☐ Infuse zoledronic acid 5 mg as a single dose once yearly ☐ Other: _____ **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. Observe the patient for at least 30 minutes post-infusion. **Special instructions or comments:** _____ Alberta Blue Cross Special Authorization has been submitted. ☐ No ☐ Yes	1. I, the prescriber, have provided a lab requisition for: Paget's Disease: ☐ ALP at 6-12 weeks after infusion ☐ CrCl ☐ Ca ☐ Other: _____ ☐ N/A Date: _____ 2. I, the prescriber, have confirmed that the patient has booked a follow-up appointment. Date: _____ ☐ N/A 3. Patient has been advised to take vitamin D and calcium supplementation prior to and after the infusion. 4. Patient has been advised to drink 500 mL water before and after the infusion.

PRESCRIBER INFORMATION

Name:	Signature:	Date:	Ph: Fax:

CONFIDENTIALLY FAX WITH THE PATIENT'S CONSENT TO: Sandstone Pharmacies **Fax #: 403-236-0846**