PerCuro Clinical Research Ltd.
305-1120 Yates Street
Victoria BC V8V 3M9
Phone: 250 382 6270
Fax: 250 382 6273

STEPS:
1. Complete all sections of form
2. **Fax** completed form to PerCuro at **250 382 6273**

Zoledronic Acid Order to Infuse

Patient Profile

Last name:	First name:	Patient DOB dd/mmm/yyyy:
Phone:	Alternate:	Sex: ☐ M ☐ F ☐ Other
PHN:	Number of prior Zoledronic Acid Infusions: #	
Address:		
City:	Province:	Postal Code:
Caregiver (if applicable):	Name:	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**	