PerCuro Clinical Research

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 Clinics at **250 382 6273**

Zoledronic Acid (DIN: 02444739 - MDA 4mg/5mL) 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: # Patient medically cleared to proceed with infusion on or after _____ (dd/mmm/yyyy)	
Caregiver (if applicable):	Name:	Phone:
Address: City:	Province:	Postal Code:

Physician Information

Prescription for Zoledronic Acid: DIN: 02444739 - MDA 4mg/5mL Single-Use Vial

Physician Stamp	Please check use: ☐Bone Metastasis ☐Tumor-Induced Hypercalcemia (TIH) ☐Bone Metastases due to multiple myelomas
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	