Wellspring INFUSION CLINIC

Zoledronic Acid Referral Form

Patient information

Patient Name: _____ **Date of Birth (dd/mm/yyyy):** _____

Phone Number: _____ **PHN:** _____ **Email Address:** _____

Current Address: _____

Bone Health Services

☐ Pharmacare Special Authority Applied. Date Submitted: _____

☐ Assistance with Third-Party Insurance Special Authority Application

Prescription

☐ Zoledronic acid 4mg/5mL (Zometa) every month x ____ IV infusions

☐ Renal adjustment: ____ mg every month x ____ IV infusions

Duration: ☐ One-time only ☐ Monthly ☐ Annual

☐ Zoledronic acid 5mg/100mL (Aclasta) x 1 IV infusion

Duration: ☐ One-time only

Delivery: ☐ Pick up at pharmacy ☐ Delivery to Wellspring

Three locations to serve you:

☐ **Wellspring Vancouver**
510-943 West Broadway

Please fax to Wellspring Infusion Clinic at 604-239-5050
This prescription will be filled by Wellness Pharmacy located at 109- 805 West Broadway, Vancouver

☐ **Wellspring Surrey**
106-12565 88 Avenue

Please fax to Wellspring Infusion Clinic at 604-239-5050
This prescription will be filled by NAZ's Pharmacy located at 101-12565 88 Ave, Surrey

☐ **Wellspring Abbotsford**
102-2180 Gladwin Road

Please fax to Wellspring Infusion Clinic at 604-239-5050
This prescription will be filled by Wellness Pharmacy located at 102-2180 Gladwin Road, Abbotsford

Lab Work

Calcium, Creatinine, Albumin, and eGFR completed within the past month?

☐ Yes ☐ No – Sending lab requisition to patient

Relevant Patient Information

Does the patient have uncorrected hypocalcemia prior to infusion?	☐ Yes	☐ No
Has the patient experienced an allergic reaction to infusions in the past?	☐ Yes	☐ No
Has the patient had a hypersensitivity reaction to bisphosphonates?	☐ Yes	☐ No
Has the patient experienced difficulty with IV starts or been informed they have difficult veins for IV insertion?	☐ Yes	☐ No
Is the patient currently pregnant? (If yes, this medication is contraindicated for pregnancy)	☐ Yes	☐ No
Is the patient currently breastfeeding?	☐ Yes	☐ No

Other Infusion Prescriptions

If you would like to prescribe additional infusion medications, please attach the prescription, order, supporting paperwork, and/or lab work. Or, please contact us by phone.

Dr. Name: _____ **Dr. Signature:** _____ **College ID:** _____ **Date:** _____

Wellspring Infusion Clinic does not provide services to patients under 18 years old or to pregnant women.