Alberta Health Services

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB*(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X)		

Zolendronic Acid - Endocrinology Treatment

This form is intended for submitting treatment requests to hospital Day Medicine departments.

Note: As part of a pilot project, only **Red Deer Regional Hospital Centre Day Medicine** is currently set up to receive referrals through this process.

Referrals may be submitted by **physicians with admitting privileges at Red Deer Hospital**, with or without Connect Care access. All referring prescribers must include current telephone contact information and remain available to Day Medicine staff during regular business hours

Treatment Requirements			
Type of Treatment	☐ New	☐ Renewal	
Consent for Treatment - Required	☐ Attached	Past Medical History - Required	☐ Attached
Current Medications - Required	☐ Attached	Relevant Blood Work	☐ Attached
Allergies			☐ No Known Allergies

Goals of Care Designation

☐ R1 ☐ R2 ☐ R3 ☐ M1 ☐ M2 ☐ C1 ☐ C2

Confirm Indication for Treatment/Problem

Select at least 1 of the following

☐ Osteoporosis

☐ Paget's bone disease

☐ Other: _____

Appointment Request

☑ Infusion Appointment Request ☐ Once ☐ Every ___ weeks for ___ treatments

Patient Care Orders

☑ Nursing Communication – Patient is to drink 500mL of water pre and post infusion

Pre-Procedure

☑ Insert peripheral IV

☑ Vital Signs

Infusion

☑ Zoledronic acid 5mg in mannitol 5% water 100mL injection

Post - Infusion

☑ Vital Signs, once

Emergency Medications

☑ acetaminophen 325 to 650mg, q4h oral, as needed – mild pain

☑ dimenhyDRINATE 20 - 50 mg Oral/IM/IV, once, as needed – nausea / vomiting

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Discharge Instructions

☑ Nursing Communication - Discharge 30 minutes after infusion is complete

☑ Remove Peripheral IV, once infusion is complete

Name MRHP		Designation
Phone	Fax	Pager / Cell Phone
Signature		Date *(dd-Mon-yyyy)*

Additional Patient Information

Name of Caregiver / Guardian / Alternate Decision Maker	Relationship	Phone

Interpreter Required ☐ No ☐ Yes ► Specify Language _____

Special Considerations for Care: