



P R O V I S

Provis Patient No.				

MEDICATION ORDER FORM

Zoledronic Acid (Zometa ®)	
Patient's Surname	Given Name & Initials
Date of birth	
<div style="display: flex; justify-content: space-around;"> ____ / ____ / ____ </div> <div style="display: flex; justify-content: space-around; font-size: small;"> dd mm yyyy </div>	
Referring MD/Oncologist	
Medication prescribed	
Zoledronic Acid 4.0 mg (or mg) in 100 mL NS IV over 15 minutes Administer <input type="checkbox"/> q 3 weekly OR <input type="checkbox"/> q 4 weekly (please indicate which schedule)	
(For Provis Use Only)	
Tx 1: _____	Tx 4: _____
Tx 2: _____	Tx 5: _____
Tx 3: _____	Tx 6: _____
Scheduled Frequency	
Repeat every 3 or 4 weeks for a total of 6 treatments (i.e. 18 or 24 weeks)	
Physician's Signature (Referring Oncologist)	_____ / _____ / _____ dd mm yyyy
Signature of Provis Physician	_____ / _____ / _____ dd mm yyyy
Repeat Order:	
Each cycle requires a new medication order after 6 treatments.	
Fax completed form to: 416-532-3635	