# PRESCRIPTION AND ENROLMENT FORM

Teva Osteoplan Infusion Program
**T** 1-844-241-0155 **E** *tevaosteoplan@coverdaleclinic.com*

**Teva PrZoledronic Acid Injection 5 mg/100 mL**

## PATIENT INFORMATION

| Last name | First name | Date of birth (MM/DD/YY) | Sex ❑ F ❑ M |
|---|---|---|---|
| | | | |

| Home address | City/Province | Postal code |
|---|---|---|
| | | |

| Home phone number | Mobile phone number | Alternative contact name | Alternative contact number |
|---|---|---|---|
| | | | |

## PATIENT CONSENT (THIS SECTION TO BE COMPLETED BY THE PATIENT)

**I, _____ (Print name), the undersigned, understand the services offered by Teva Osteoplan.** My physician has explained the purpose and expected benefits of zoledronic acid, and all of my questions regarding the medication have been answered. I authorize my physician to disclose to Coverdale and its authorized representatives my personal information necessary for my prescription to be filled, including the information on this referral form (as used in this consent, the term "personal information" includes "personal health information") and to the collection, use and disclosure of my personal information. I authorize and consent to Coverdale and its authorized representatives using my personal information solely for the dispensing of zoledronic acid. I understand that if my personal information is to be used for a purpose not previously identified, such new purpose will be identified to me, and my further consent will be obtained prior to my personal information being used. I understand that I may arrange to access the personal information held by Coverdale, and may rectify any deficient information, by contacting Coverdale in writing at Coverdale, Teva Osteoplan Infusion Program, 2848 Main St. Hillsborough, NB E4H 2Y7 attention Privacy Officer. I understand that I may revoke this consent at any time by writing to Coverdale at the address above. If I revoke my consent, no further collection, use or disclosure of my personal information will occur. I can obtain a copy of Coverdale's privacy policies at coverdaleclinic.com/privacypolicy.html or by calling 1-844-241-0155 and asking for the Privacy Officer.

I consent to the collection, use and disclosure of personal information as described above. ❑ Yes ❑ No

| Patient/caregiver signature or verbal consent obtained by | Date |
|---|---|
| | |

## PHYSICIAN INFORMATION

| Last name | First name | Licence number |
|---|---|---|
| | | |

| Address | City/Province | Postal code |
|---|---|---|
| | | |

| Work phone number | Work fax number | Email |
|---|---|---|
| | | |

## Rx: PLEASE MARK CLEARLY

**It is vital the information below is accurate to ensure there are no contraindications prior to the infusion.**

Previous treatment with PrZoledronic Acid Injection? ❑ Yes ❑ No

Current use of Calcium supplements? ❑ Yes ❑ No

Current use of Vitamin D supplements? ❑ Yes ❑ No

Renal function tested recently and within normal range? ❑ Yes ❑ No

❑ **Teva PrZoledronic Acid 5 mg** in 100 mL aqueous solution IV x 1 infusion to be infused in no less than 15 minutes.

❑ Other

| Physician signature | Date | Licence number |
|---|---|---|
| | | |

**Fax completed form to 1-844-394-0094 or email to *tevaosteoplan@coverdaleclinic.com*.**