

Cedar Specialist Group 7

599 Birch Rd Nanaimo ON, Canada V6K 7P6

Fax Cover Sheet

To: Dubois Phone:(000) _-____ Fax: (496) 210-6398 4

Date: 2025-Aug-17

From: Dr. Pablo Dubois (Endoscopy) Phone: (454) 930-9158 Fax: (454) 930-9158

Check out our new website at www.brookfieldmedicalcentreeast.ca

Number of pages including cover: 17

Re: Zola Nguyen

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Hospital Report

Patient	Nguyen, Zola	Home Phone	(454) 930-9158	Work Phone	
Health #	1287070723LW	Sex	F	Patient ID	67531
Age	29 years				
DOB	1996				

Facility Report #: DCUX27359480-92497

Sent to: Dubois, Pablo Reported By: Facility #0745

Collection Date: 2025-Aug-17 Reviewed: 2025-Aug-17 by Dubois

Message Unique ID: 66922339493429427^783687616.6170^2509^UA^HFXS20287615-62183^775602328370^E^^N^SJ0643548/35^894

Source Author: 49913^Dubois

Updated On: 2025-Aug-17 3:13 AM

Flags	Results	Ref Range
MEDICAL RECORDS (S)		
Nanaimo Endo Operative Report	See Below	

Cedar Specialist Group 7
599 Birch Rd
Nanaimo, ON V6K 7P6
Phone: (454) 930-9158
Fax: (251) 680-8660

Nanaimo Endo Operative Report

Patient: Nguyen, Zola HYW: A623421908
DOB/Age/Sex: 1996 / 29 / F Cxup: FT2452689/64
HCN: 2893386601-KJ Outpt/ED Date: 17/08/2025 Admit Date:
Address: 579 Harlow Blvd Report Number: DCUX27359480-92497
Nanaimo, ON H1L 7N8 Patient Location: Cedar Specialist Group 8
Phone Number: (919) 340-3971 Patient Rm/Bed:

Attending Provider: Dubois, Pablo
Primary Care Provider (Family Provider): Richardson, Caleb
Copies To: Dubois, Pablo; Richardson, Caleb

Provider Note
Clinic Note

PROCEDURE: Colonoscopy

PRE-PROCEDURE DIAGNOSIS: Crohn's disease with prior ileocolic resection.

POST-PROCEDURE DIAGNOSIS: Rutgeerts 2 with numerous aphthous ulcers throughout neoterminal ileum. Ongoing mild psoriasis requiring topical treatment. Will switch biologic treatment from infliximab to Skyrizi. Follow-up 2 to 3 months.

CLINICAL HISTORY: Zola was seen today for purpose of colonoscopy. As you know she had a prior ileocolic resection back in October 2024 and she has been having some ongoing loose bowel movements but no obstructive type symptoms. She often goes 3-4 times per day but no blood or mucus in the stools. She continues to experience some psoriatic rashes over her knees and arms. Seems better with topical treatment. No weight loss. No upper GI symptoms. Review of systems otherwise unremarkable.

PAST MEDICAL HISTORY: Crohn's disease (treated with Stelara, Remicade, laparoscopic ileocolic resection), cholecystectomy for gallstones, psoriasis (affecting scalp and groin, likely related to infliximab, treated with topical cream)

MEDICATIONS: Restoralax 17g PO daily, infliximab 500mg (10mg/kg) q6 weeks, ocp PO, iron supplement PO

ALLERGIES: No known allergies

SOCIAL HISTORY: Non-smoker, rare alcohol use, no illicit drug use, used to work at follow-up in child care; currently going back to school for hr at Cedar Specialist Group 7 online courses

FAMILY HISTORY: Paternal uncle: Crohn's disease.

LABS: (2025-Mar-09): HgB: 149 g/L, MCV: 90 fL, WBC: 9.7 x E9/L, Lymph: 3.5 x E9/L, Neut: 5.4 x E9/L, Plt: 286 x E9/L, ALT: 27 U/L, AST: 22 U/L, ALP: 86 U/L, Bili: 8 umol/L, Direct bili: 2 umol/L, Alb: 43 g/L, Iron: 16.6 umol/L, iron sat: 0.22, CRP: 7.9 mg/L, (2024-Jul-09): Cr: 68 umol/L, Ferritin: 33 ug/L, (2025-Jun-01): Infliximab drug level: 13.690 ug/mL.

ENDOSCOPIC EVALUATION: Colonoscopy - October 2018 by Dr. Dalton; Findings: noted narrowing at the Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

level of the terminal ileum; remainder of the colon appeared unremarkable; biopsies were performed during the procedure; Pathology: biopsies taken from the terminal ileum showed inflammation consistent with Crohn's disease; colon and rectal biopsies were normal.

IMAGING: None since surgery.

PHYSICAL EXAM: Head and neck exam was unremarkable. Abdominal exam revealed a soft, non-distended, non-tender abdomen with no appreciable organomegaly or stigmata of chronic liver disease. There was no swelling or erythema of the lower extremities.

INFORMED CONSENT: We discussed the benefits, risks, and alternatives to the procedure including the risk of sedation, aspiration, bleeding, infection, perforation, and missed lesions. All questions were answered and written informed consent was obtained. The patient was brought into the endoscopy suite in stable condition.

PROCEDURE: The patient was placed in the left lateral decubitus position and intravenous sedation was provided by the anesthesiologist. A digital rectal exam was performed and there were no abnormalities. An adult colonoscope was advanced through the anus all the way to the neoterminal ileum without difficulty. The Boston bowel prep score was 2,2,2 requiring minimal suctioning of liquid stool contents throughout. The total withdrawal time was approximately 8 minutes. I carefully inspected the entire colon including the right colon twice in forward flexion. Rectal retroflexion was performed. The scope was removed after decompressing the bowel. The patient tolerated the procedure well without complication. The patient will be monitored in the recovery room and discharged post procedure.

FINDINGS: Neoterminal ileum was intubated about 20 cm and the distal 10 cm had countless aphthous ulcers, Rutgeerts Score 2. No erythema or deep ulceration. No strictures. Anastomosis widely patent. Remainder the colon was otherwise unremarkable.

IMPRESSION AND PLAN: Zola has endoscopic recurrence approximately 9 months after an ileocolic resection for Crohn's disease. She is also struggled with ongoing psoriasis and I think it be prudent to switch therapies both to reduce ongoing psoriasis and of course optimize treatment of her recurrent Crohn's disease. We discussed various options and we have elected to go with Skyrizi and she will make the switch shortly and I will follow-up with her in a few months and likely plan for repeat colonoscopy in 6 to 9 months for reassessment. If she continues to have some loose bowel movements we could also try some cholestyramine and even a course of rifaximin for possible small intestinal bacterial overgrowth that can sometimes occur post ileocolic resection. I will follow-up with her in a few months and she knows to contact me in the meantime if there is any questions or concerns.

Thanks for involving me in this patient's care and please don't hesitate to contact me if you have any questions or concerns.

Report Status: Signed Dictated By: Dubois, Pablo

<Electronically signed by Pablo Dubois>

Dictated Date/Time: 17/08/2025 3:13 AM Transcribed Date/Time: 17/08/2025 3:13 AM

This report may have been generated using speech recognition software. If there are any concerns regarding the contents, please notify us immediately. LAB results are captured at the point in time of report dictation, please review Cedar Specialist Group 7 for current LAB results.

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Principal Author: Dubois, Pablo

Lab Order #: 5333858 Ordered By: Pablo Dubois Reported By: Cedar Specialist Group 7

Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

(454) 930-9158 08/17/2025 3:13 AM

Collection Date: 2025-Jun-01 Reviewed: 2025-Jun-09 by Dubois Reported Date: 2025-Jun-08 3:13 AM
Updated On: 2025-Jun-09 3:13 AM

	Flags	Results	Ref Range	Units
Infliximab Drug Level*				
Infliximab Drug Level* Biochemistry (F)		13.690		ug/mL
Interpretation:				
Supratherapeutic level				

Anti-infliximab antibodies will not be tested

Note: *Infliximab testing procedure (Reflex Testing): Infliximab drug levels and antibodies are tested using a stepwise, reflex procedure. Infliximab drug levels are tested initially and reported. If the Infliximab drug level is undetectable (≤ 0.035 ug/mL) then anti-Infliximab antibody levels will be tested and reported.

Method: Quantitative detection of infliximab in human serum is performed with the Promonitor IFX enzyme-linked immunosorbent assay (ELISA). As of [REDACTED-DATE], the upper limit of quantification was modified, by the manufacturer, from 28.8 ug/mL to 25.4 ug/mL.

Reference cut-points defined by a consensus of gastroenterologists, applicable in the context of inflammatory bowel diseases:

Subtherapeutic level: < 3 ug/mL Therapeutic level: $3 - 7$ ug/mL Supratherapeutic level: > 7 ug/mL

Infliximab therapy is indicated for a number of inflammatory diseases like rheumatoid arthritis and IBD including Crohn Disease and Ulcerative Colitis.

Accession Id: 5333858 (Final) Ordered By: Pablo Dubois Reported By: Cedar Specialist Group 7 Collection Date: 2025-Mar-09 Reviewed: 2025-Mar-10 by Dubois Service Date: 2025-Mar-09 Reported Date: 2025-Mar-10 3:13 AM

CC: Diego Rossi Updated On: 2025-Aug-17 3:13 AM

RENAL ASSESSMENT =====	Results	Flags	Ref Range	Test Loc
CREATININE	67		50 - 100	umol/L 10
eGFR	110		See below	
	Results rule out CKD stage 3-5. Assessment of urine ACR is required to definitively rule out or confirm CKD diagnosis. The Kidneywise toolkit (www.brookfieldmedicalcentreeast.ca) recommends remeasuring eGFR and urine ACR annually for people with diabetes mellitus and less frequently in others unless clinical circumstances dictate otherwise.			
	Reference interval: >=60 mL/min/1.73m2			
	eGFR is calculated using the CKD-EPI 2021 equation which does not use a race-based adjustment.			

599 Birch Rd 330 Glenarm Blvd J4D 5E0 (454) 930-9158

Accession Id: 5333858 (Final) Ordered By: Pablo Dubois Reported By: Cedar Specialist Group 7 Collection Date: 2025-Mar-09 Reviewed: 2025-Mar-10 by Dubois Service Date: 2025-Mar-09 Reported Date: 2025-Mar-10 3:13 AM

CC: Diego Rossi Updated On: 2025-Aug-17 3:13 AM

ROUTINE CHEMISTRY	Results	Flags	Ref Range	Test Loc
ASPARTATE TRANSAMINASE (AST)	22		< 30	U/L 10
ALANINE TRANSAMINASE (ALT)	27		< 36	U/L
ALKALINE PHOSPHATASE	86		35 - 120	U/L

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Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

(454) 930-9158 08/17/2025 3:13 AM

Ordered By: Pablo Dubois Collection Date: 2025-Mar-09 Service Date: 2025-Mar-09 Report Date: 2025-Mar-10 3:13 AM Reported By: Cedar Specialist Group 7 Reviewed: 2025-Mar-10 by Dubois

CC: Diego Rossi Updated On: 2025-Aug-17 3:13 AM

Results	Flags	Ref Range	Units	Test Loc
ROUTINE CHEMISTRY				
TOTAL BILIRUBIN	8		< 20	umol/L
DIRECT BILIRUBIN:CONJUGATED	2		< 7	umol/L
IRON	16.6		10.6 - 33.8	umol/L
TRANSFERRIN	2.93		2.00 - 4.00	g/L
TIBC	74		50 - 100	umol/L
TRANSFERRIN SATURATION	0.22		0.13 - 0.50	

599 Birch Rd 330 Glenarm Blvd J4D 5E0 (454) 930-9158

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CC: Diego Rossi Updated On: 2025-Aug-17 3:13 AM

Results	Flags	Ref Range	Units	Test Loc
ROUTINE CHEMISTRY				
ALBUMIN	43		35 - 52	g/L
C-REACTIVE PROTEIN	7.9	HI	< 5.0	mg/L
	Test method: Abbott Alinity CRP, suitable for cardiovascular disease assessment and detection of active inflammation.			
	CRP >=2.0 mg/L is a risk-enhancing factor for cardiovascular disease, as defined in the Guidelines of the American Heart Association and the American College of Cardiology (JACC 2019; 74: e177).			
	CRP results >=5.0 mg/L may be due to acute inflammation.			

599 Birch Rd 330 Glenarm Blvd J4D 5E0 (454) 930-9158

Accession Id: 5333858 (Final) Ordered By: Pablo Dubois Collection Date: 2025-Mar-09 Service Date: 2025-Mar-09 Report Date: 2025-Mar-10 3:13 AM Reported By: Cedar Specialist Group 7 Reviewed: 2025-Mar-10 by Dubois

CC: Diego Rossi Updated On: 2025-Aug-17 3:13 AM

Results	Flags	Ref Range	Units	Test Loc
HEMATOLOGY I				
WBC	9.7		4.0 - 11.0	x E9/L
RBC	4.90		4.00 - 5.10	x E12/L
HEMOGLOBIN	149		120 - 160	g/L
HEMATOCRIT	0.440		0.350 - 0.450	L/L
MCV	90		80 - 100	fL
MCH	30.4		27.5 - 33.0	pg
MCHC	339		305 - 360	g/L
RDW	12.6		11.5 - 14.5	%
PLATELET COUNT	286		150 - 400	x E9/L

599 Birch Rd 330 Glenarm Blvd J4D 5E0 (454) 930-9158

Accession Id: 5333858 (Final) Ordered By: Pablo Dubois Collection Date: 2025-Mar-09 Service Date: 2025-Mar-09 Report Date: 2025-Mar-10 3:13 AM Reported By: Cedar Specialist Group 7 Reviewed: 2025-Mar-10 by Dubois

CC: Diego Rossi

Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

Updated On: 2025-Aug-17 3:13 AM

	Results	Flags	Ref Range	Test Loc
HEMATOLOGY II				
NEUTROPHILS	5.4		2.0 - 7.5	x E9/L 10
LYMPHOCYTES	3.5		1.0 - 3.5	x E9/L
MONOCYTES	0.7		0.2 - 1.0	x E9/L
EOSINOPHILS	0.2		0.0 - 0.5	x E9/L
BASOPHILS	0.0		0.0 - 0.2	x E9/L

	Results	Flags	Ref Range	Test Loc
IMMATURE GRANULOCYTES	0.0		0.0 - 0.1	x E9/L
NRBC	0			/100 WBC

599 Birch Rd 330 Glenarm Blvd J4D 5E0 (454) 930-9158

Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

Sunnymede Family Practice 7

199 Kestrel Blvd Nanaimo ON, Canada V6K 7P6

Fax Cover Sheet

To: Dr. Diego Rossi Phone: (610) 219-1236 Fax: (692) 284-3928

Date: 2025-Feb-03

Check out our new website at www.brookfieldmedicalcentreeast.ca

From: Dr. Pablo Dubois Phone: (712) 275-4756 Fax: (749) 476-8640

Number of pages including cover: 4

Re: Zola Nguyen

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Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

Dr. Pablo Dubois

Cedar Specialist Group 7 876 Lakeview Blvd Nanaimo, ON V6K 7P6 Phone: (454) 930-9158 Fax: (454) 930-9158

2025-Feb-03

Dr. Diego Rossi 599 Birch Rd Nanaimo, ON V6K 7P6

Patient: Mrs. Zola Nguyen **PHN:** 7991 800 998CS **Birthdate:** 1996 **Phone Number:** (919) 340-3971 ext. cell, **Work:** (454) 930-9158 **Cell:** (919) 340-3971 **Address:** 579 Harlow Blvd, Nanaimo, ON H1L 7N8
Provider Billing No.: 807072

Dear Dr. Rossi,

Zola was seen for reassessment and ongoing management of her Crohn's disease.

The patient was given an option for in person or virtual visit and prefers a virtual visit by video. The entire visit was done as per usual standards with the exception of a physical exam.

Past medical history:

1. TI Crohn's disease - Dx in 2018 when she presented with SBO. MRE showed 15-20cm active TI disease. Started on Stelara March 2019 and despite optimization to every 4 weeks still ongoing disease activity clinically and on MRI so switched to Remicade March 2021 and doing better since. Laparoscopic ileocolic resection by Dr. Boyd on Nov 17, 2024. Pathology consistent with Crohn's disease.
2. Psoriasis affecting scalp and groin - likely related to IFX - tx with topical cream
3. Cholecystectomy for gallstones in 2016.

Current medications: Infliximab 500mg (10mg/kg) q6 weeks, iron supplement, OCP, Restoralax 17g daily

Allergies: None.

Social history: Non-smoker, rare EtoH, no illicit drugs. Used to work at follow-up in child care. Going back to school for HR at Cedar Specialist Group 7 Online courses.

Family history: Paternal uncle with Crohn's disease.

History of presenting illness: Doing great for surgery. Feels well. Having 1-2 soft BM/day, no blood, no urgency, no tenesmus. No abdominal pain. No obstructive symptoms. Appetite, energy, and weight stable. No extraintestinal manifestations of IBD. Rash in groin and scalp area well controlled. Review of systems otherwise unremarkable.

Labs: 2024-Jul-09 - HgB 149 g/L, WBC 11.5 x E9/L, Platelets 317 x E9/L, ALT 30 U/L, AST [REDACTED-DATE] U/L, ALP 107 U/L, Bilirubin 8 umol/L, Creatinine 68 umol/L, CRP 8.6 mg/L, Iron Saturation 0.34, Ferritin 33 ug/L, Albumin 40 g/L

Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

TDM level: Infliximab TDM was done Nov 12, 2024 and was 18.58. Infliximab TDM done Dec 20, 2023 was 13. Infliximab TDM done Jul 4, 2023 was 16.

Stool studies: Fecal calprotectin done Feb 20, 2023 was 1334. Calprotectin on May 31, 2022 was 888. Calprotectin on Apr 7, 2021 was 272. Calprotectin Nov 22, 2020 was 674. Fecal Cal March 2020 was 513 - Calprotectin in July 2019 was 133.

Endoscopic evaluation: Colonoscopy was performed on Sep 15, 2024 and showed an unremarkable colon with ileocecal valve narrowed, unable to traverse.

Colonoscopy was performed on Jun 11, 2023 and was normal to terminal ileum. One small descending colon polyp was removed. Pathology showed nonspecific regenerative change.

She underwent a colonoscopy with Dr. Dalton in [REDACTED-DATE-BELOW-YEAR-PRECISION] which point a he noted narrowing at the level of the terminal ileum and the remainder of the colon appeared unremarkable. Biopsies showed inflammation within the terminal ileum consistent with Crohn's disease. Colon and rectal biopsies were normal.

Imaging: MR enterography was done May 28, 2024 and was relatively similar to previous study done in September 2022. Findings suggest acute on chronic IBD. There does appear to be some narrowing involving the lumen and some mild proximal distention. Findings suspicious for an element of associated obstruction.

MRI done Oct 10, 2022 shows circumferential bowel wall thickening with mucosal hyperenhancement and progressive enhancement at the terminal/distal ileum involving a 15-20cm segment. Small bowel is dilated up to 5.5cm with fluid contents suggesting a degree of luminal stricturing. No obstruction but suggestive of fibrostenotic disease.

MRI on Mar 14, 2021 showed increased segmental length of abnormal distal ileal small bowel loops (now 16cm, previously 10 cm), extending to the ileocecal valve. Associated with similar degree of mild- moderate luminal narrowing but demonstrating enhancement characteristics suggestive of superimposed mild acute on moderate chronic small bowel inflammation. Mild fluid increased fluid filled prominence of the small bowel loops, without obstruction.

MRI September 2019 showed 10 cm of terminal ileum extending to ileocecal valve with mild upstream dilation. Additional 2 cm segment of fibrostenotic changes in the mid ileum with minimal upstream dilation.

MRI February 2019 showed 15-20 cm length of terminal ileal disease and proximal to that there was dilation of the small bowel up to 5 cm.

Impression/Plan: Zola is doing great since her ileocolic resection. She will remain on Infliximab for now and her psoriatic lesions seem to be quite stable on topical therapy. I will plan for colonoscopy in about 6 months from now to rule out any endoscopic recurrence. I look forward to seeing her then.

IBD Plan:

1. Maintain up to date vaccinations with GP.
2. Avoid NSAIDs and anti-inflammatories which can cause flares of IBD, tylenol is safe.
3. Patient counselled on risks and side effects of current medical therapy.
4. Patient knows to contact me if they develop signs of a disease exacerbation including worsening abdominal pain, diarrhea, or blood in the stools.

Thank you for involving me in the care of this patient. Please don't hesitate to contact me at any time

Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

if you have any questions or concerns.

Sincerely,

! [signature]

Pablo Dubois **Electronically Reviewed to Expedite Delivery**

Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

Cedar Specialist Group 7 Cedar Specialist Group 7

Lab Results: Generated On 2025-Aug-17

Patient	Nguyen, Zola	Ontario Health Number	7991 800 998CS
Date of Birth	1996		
Age (Time of Observation)	28 years	Telephone	996-980-7696 (Primary Residence Number)
Sex	F	Email Address	zola.nguyen55@westbrookmedicalassociates.ca
Address	579 Harlow Blvd Nanaimo ON H1L 7N8 (Home)		

Comments Vantage Label 7 Specimen A Cold Ischemic Time Calculation (mins) 12 Date Specimen Removed From Body [REDACTED-DATE] Date Specimen in Fixative [REDACTED-DATE] Pre-op & Clinical HX: crohns disease Time Specimen in Fixative 3:13 AM Time Specimen Removed From Body 3:13 AM Cedar Specialist Group 7 (Lab Cedar Specialist Group 8)

Lab Order #	Ordering Practitioner	Primary Performing Lab
5333858 Cedar Specialist Group 7 (Lab Cedar Specialist Group 8)	Popov, Emeka (Gloria Langlois)	Cedar Specialist Group 7 (Lab Cedar Specialist Group 8)
Last Updated in Cedar Specialist Group 7	Address	Address
2024-Nov-25 0:74:50 PM EST	599 Birch Rd Nanaimo ON V6K 7P6 Cedar Specialist Group 7 (Firm/Business)	115 Sherwood Blvd Nanaimo T8X 0V9 ON (Firm/Business)
Specimen Received Date/Time		Primary Reporting Lab
2024-11-17 2:72:60 PM EST		Cedar Specialist Group 7 (Lab Cedar Specialist Group 8)
		Address

		115 Sherwood Blvd Nanaimo T8X 0V9 ON (Firm/Business)
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Pathology

Specimen Type	Collection Date	Specimen Collected By
Tissue	2024-Nov-17 01:05:90 PM EST	Cedar Specialist Group 7
Site Modifier: Surgical Pathology		(Lab Cedar Specialist Group 8)

Flags	Results	Reference Range	Units

Surgical Pathology

Site Of Origin Result: A. Colon, ILEOCOLIC RESECTION **Relevant History** Result: CROHN'S DISEASE
Gross Description Result: The specimen is received in one part. A. The specimen, received in formalin, labeled with the patient's identification, Vantage tag and "A ileocolic resection", consists of: Procedure: Ileocolic resection Dimensions and description: Terminal ileum (Length 22.0 cm, Proximal circumference 7.5 cm-stapled) with attached mesentery (depth 5.5 cm): Proximally, the mucosa is tan with edematous mucosa and normal- appearing mucosal folds. Approximately 10.0 cm from the proximal resection margin is an ill- defined transition to tan irregular mucosa with loss of mucosal folds. Wall thickness measures 0.2-0.5 cm and is partially infiltrated by adipose tissue. No definite masses, lesions or other abnormalities can be identified. Ileocecal valve: Patent and distorted by a submucosal deposit of adipose tissue Appendix (Length 6.5 cm, Diameter 0.7 cm): The serosa is tan with the serosal capillaries injected. Lumen is patent and filled with tan friable material. The mucosa is tan and unremarkable. Wall thickness measures 0.2-0.3 cm. No masses, lesions or abnormalities can be identified. Colon (Length 9.3 cm, Distal circumference 7.0 cm) with attached pericolic soft tissue (depth 2.0 cm): The mucosa is tan and edematous with normal- appearing mucosal folds. No masses, lesions or abnormalities can be identified. Possible lymph nodes: None sampled Ink Code: Silver-all surfaces, Green-proximal and distal bowel end resection margins Representative sections: A1 proximal and distal resection margin, perpendicular sections A2-A4 random full-thickness cross-sections submitted from proximal-distal (2 pieces in each)

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A5 appendix: Longitudinal section of tip and 2 full-thickness cross-sections A6 mesenteric margin, en face 21/11/2024 3:13 AM / LL **Final Diagnosis** Result: A. Ileocolic resection (ileum: 22.0 cm and colon : 9.3 cm):

- Chronic active ileocolitis with ulceration, fibrosis and transmural chronic inflammation compatible with Crohn's disease
- No granulomas or dysplasia
- Margins negative for dysplasia or malignancy
- Appendix within normal limits 5/pr **Provider; Signing** Result: Signed by: Hargreaves, Emeka 25/11/2024

CC List Rossi, Diego (Cesar Ghosh)

Admitting Provider Popov, Emeka (Gloria Langlois)

Attending Provider Popov, Emeka (Gloria Langlois)

CONFIDENTIAL - report contains Personal Health Information Generated from Cedar Specialist Group 7 on 2025-08-17 83:30:72 EDT by user Pablo Dubois

Cedar Specialist Group 7 **ClinicalViewer**

Nguyen, Zola DOB: 1996 (28y) Female HCN: 7123642028

Operative Report - 20 Nov 2024 21:52 (Riverside Medical Centre 4) Provider: Popov, Emeka Status: Final

Operative Report Riverside Medical Centre 4

115 Sherwood Blvd Nanaimo, ON T8X 0V9 Phone: (760) 781-3742 Fax: (760) 781-3742

Operative Report

Patient: Nguyen, Zola DOB/Age/Sex: 1996 / 28 / F HCN: 2893386601-KJ Address: 579 Harlow Blvd Nanaimo, ON H1L 7N8 Phone Number: (760) 781-3742 HYW: A623421908 Ffig: TY0845192/89 Visit Date: Report Number: 3547-06708 Patient Location: Morris Patient Rm/Bed: Morris

Attending Provider: Boyd, Kira Primary Care Provider (Family Provider): Richardson, Caleb Copies To: Richardson, Caleb; Boyd, Kira

Operative Report Operative Details

Operation Date: [REDACTED-DATE] Actual Procedures p Laparoscopic Possible Open Ileocolic Resection(Not Applicable) - Kira Boyd

Anesthesia Type General

Case Staff Anesthesiologist: Dr. Zhang Surgical Assist: Nowak, Nina

Surgeon: Emeka Popov

Details of Procedure Preoperative diagnosis -ileocolic Crohn's disease

Postoperative diagnosis same

Procedure: Laparoscopic ileocolic resection

Operative note: This pleasant patient was brought to the operating room under general anesthesia prepped and draped appropriately in the supine position with the left arm tucked in.

Preoperative checklist and consent was obtained. Risks of the procedure including infection,

Page No: 1

Privacy Disclaimer: *This information is confidential and may only be used by the patient or individual listed in the footer. If found, please return to the organization listed in the footer. Shred when no longer needed.* Page 12 of 16 Generated from Cedar Specialist Group 7 Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996 User Id: rr-Gdq 9humzWJACDphUqvF9U1ztBUE- Organization: Dr. Pablo Dubois Date: 03 Feb 2025 08:34

Nguyen, Zola DOB: 1996 (28y) Female HCN: 7123642028 Cedar Specialist Group 7

Operative Report - 20 Nov 2024 21:52 (Riverside Medical Centre 4) Provider: Popov, Emeka Status: Final
bleeding, conversion to open as well as risk of injuries to adjacent tissues were discussed in great detail.

We started by making a supraumbilical skin incision using a 11 blade scalpel dissection carried through subcutaneous tissue into the abdominal cavity and direct visualization. Two #1 Vicryl sutures were placed for stay sutures and a 10 mm Hassan trocar was placed.

We then inserted 2 additional ports a suprapubic port as well as a left lower quadrant port.

An additional 5 mm subxiphoid port was also placed.

The 10 mm laparoscope was inserted and the right colon was visualized.

I started by the mobilization from above getting into the lesser sac and mobilizing the hepatic flexure the duodenum was swept retroperitoneally and I took down the lateral attachments all the way down to the appendix I then turned my attention to doing the inferior dissection by mobilizing the small bowel bowel along the mesenteric edge keeping the right ureter in view and away from the dissection field. I then continued this dissection superiorly and once adequate mobility was obtained I made a small incision in the midline approximately 2 to 3 cm in size and placed a wound protector

I then exteriorized the specimen and divided the proximal distal bowel using the GIA 80 stapler. I then lined up the bowel in a isoperistaltic manner created 2 enterotomies away from the suture line and passed a GIA 80 stapler through this. I closed the defect using two 3-0 Vicryl sutures in a 2 layer fashion imbricating the first suture line with the second. 2 crotch sutures were placed using a 2-0 Vicryl suture.

The anastomosis was well vascularized and under no tension whatsoever.

The fascia was closed using #1 Vicryl sutures.

All skin incisions were closed using 3-0 Monocryl sutures.

Steri-Strips and dressings were applied.

Patient was extubated and taken to recovery in stable condition. No immediate complications were noted, estimated blood loss was minimal. All sponge and instrument counts were correct at the end of the case.

Report Status: Signed

Dictated By: Boyd, Kira

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Nguyen, Zola	DOB: 1996 (28y) Female	HCN: 7123642028	Cedar Specialist Group 7
--------------	------------------------	-----------------	--------------------------

Operative Report - 20 Nov 2024 21:52 (Riverside Medical Centre 4) Provider: Popov, Emeka Status: Final

<Electronically signed by Emeka Popov>

Dictated Date/Time: [REDACTED-DATE] Transcribed Date/Time: [REDACTED-DATE]

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Page No: 3

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Hospital Report

Patient	Nguyen, Zola	Home Phone	(454) 930-9158	Work Phone	
Health #	1287070723LW	Sex	F	Patient ID	67531
Age	29 years				
DOB	1996				
Facility Report #:	DCUX27359480-92497				
Sent to:	Dubois, Pablo			Reported By:	Facility #0745

Facility Report #:	DCUX27359480-92497		
Collection Date:	2024-Sep-15	Reviewed:	2024-Sep-18 by Dubois
Message Unique ID:	66922339493429427^783687616.6170^2509^UA^HFXS20287615-62183^775602328370^E^^N^SJ0643548/35^894		
Source Author:	49913^Dubois		
Updated On:	2024-Sep-18 3:13 AM		

Flags Results Ref Range

MEDICAL RECORDS (S) Nanaimo Endo Operative Report See Below

Cedar Specialist Group 7 599 Birch Rd Nanaimo, ON V6K 7P6 Phone: (454) 930-9158 Fax: (251) 680-8660

Nanaimo Endo Operative Report

Patient: Nguyen, Zola DOB/Age/Sex: 1996 / 28 / F HCN: 2893386601-KJ Address: 579 Harlow Blvd Nanaimo, ON H1L 7N8 Phone Number: (919) 340-3971

HYW: A623421908 Avdg: VT0707234/82 Visit Date: 15/09/2024 Report Number: DCUX27359480-92497 Patient Location: Cedar Specialist Group 8 Patient Rm/Bed:

Attending Provider: Dubois, Pablo Primary Care Provider (Family Provider): Richardson, Caleb Copies To: Dubois, Pablo; Richardson, Caleb; Boyd, Kira

Provider Note Clinic Note Procedure: Colonoscopy

Pre-procedure Diagnosis: Terminal ileal fibrostenotic Crohn's disease.

Post-procedure Diagnosis: Unremarkable colon and ileocecal valve narrowed and unable to traverse.

Clinical history: Please see prior clinical notes for full details. As you know Zola is currently on infliximab for fibrostenotic ileal Crohn's disease and MRI shows about 15 to 20 cm length of some narrowed bowel with some proximal upstream dilatation and she continues to have some intermittent crampy abdominal pain as well as postprandial bloating suggesting obstructive type symptoms. As such we had referred along to Dr. Boyd for consideration of the ileocolic resection it sounds like is being planned for the fall and we wanted to proceed with a preoperative endoscopic assessment just to rule out any other colonic disease.

Physical exam: Head and neck exam was unremarkable. Abdominal exam revealed a soft non-distended, non-tender abdomen with no appreciable organomegaly or stigmata of chronic liver disease. There was no swelling or erythema of the lower extremities.

Informed Consent: We discussed the benefits, risks, and alternatives to the procedure including the risks of sedation, aspiration, bleeding, infection, perforation, and missed lesions. Written informed consent was obtained. All questions were answered and patient was brought into the endoscopy suite in stable condition.

Procedure: The patient was placed in left lateral decubitus position and intravenous sedation was provided. A digital rectal examination was performed and there were no abnormalities. An adult colonoscope was advanced through the anal verge all the way to the ileocecal valve without difficulty. The Boston bowel prep was 2,2,2 requiring minimal suctioning of liquid stool contents throughout. The total withdrawal time was approximately 8 minutes. I carefully inspected the entire

Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

colon including the right colon twice in forward flexion. The findings are as follows.

Findings: Ileocecal valve appeared stenotic. No active ulceration. Unable to really see across the neoterminal ileum. Colon itself was unremarkable with no active Crohn's disease.

Rectal retroflexion was performed and was unremarkable. The scope was removed after decompressing the bowel. The patient tolerated the procedure well without complication. The patient will be monitored in the recovery room and discharged home post procedure.

Impression and Plan: Zola has fibrostenotic Crohn's disease affecting the ileocecal valve and likely the distal terminal ileum. I think given the ongoing intermittent obstructive symptoms as well as the findings on MRI is not unreasonable to proceed with an ileocolic resection with close endoscopic surveillance afterwards. I will likely keep her on infliximab perioperatively and continue it of course after the resection to reduce risk of recurrence. She seems happy with this plan and I will plan to follow-up with her in a few months for ongoing assessment. She should not interrupt her infliximab around the time of surgery.

Thanks for involving me in this patients care and please don't hesitate to contact me if you have any questions or concerns.

Dr. Pablo Dubois Gastroenterologist and Advanced Endoscopist

Report Status: Signed Dictated By: Dubois, Pablo

<Electronically signed by Pablo Dubois>

Dictated Date/Time: 15/09/2024 3:13 AM Transcribed Date/Time: 15/09/2024 3:13 AM

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Principal Author: Dubois, Pablo

Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

OCT 3, 2018 9

Fairlight Medical Centre New Patient Questionnaire

Name: Zola Nguyen Today's Date: Oct 3, 2018 Date of Birth: MAR 16, 1996 Height: 5' 2" Weight: 110
Pharmacy: Glenmore Specialist Centre Email: zola.nguyen55@westbrookmedicalassociates.ca Insurance:
Private/ ODSP/~~NONE~~

List all current medications and their dosage: PREDNISONE (5mg) VITAMIN D (1000 IU) (blank) (blank)
(blank) (blank) (blank) (blank) (blank)

List your Surgical History (and approximate date if known): Gallbladder Removal -> [REDACTED-DATE]
(blank) (blank) (blank) (blank)

Cdh Nov 8 30y -

List your Medical History (and approximate date of initial diagnosis): Gall Stones - Aug 2016 (blank) (blank)
(blank) (blank) (blank)

List any medication Allergies: N/A (blank) (blank) (blank)

Do you smoke? NO How long? N/A How many per day? N/A Do you smoke cannabis(marihuana)?
(Yes/~~No~~) How long? N/A How much per day? N/A Do you use any other recreational drugs (Yes/~~No~~) How
many alcoholic drinks do you drink during an average week? 1 or 2 (including wine & beer)

List any family history of the digestive system: (cancer of esophagus, stomach, colon, pancreas, liver, or
gallbladder) Uncle has Chrons Grandma - Stomach cancer/sensitive. (blank)

Family History - of bowel (colon) polyps: (blank) (blank)

Family History - General: (blank) (blank)

Zola Nguyen Signature: (signed) Date: Oct 3, 2018

Patient Name: Nguyen, Zola	HRN# Q897863084 Health Card# 4971549172-ER
Address: Northview Clinic Location: M.QSGAYP Room: Pt. Home # (414) 235-2294 Client: Client MRN:	D.O.B: 16/03/1996 Specimen Date: Age/Sex: 22/F 08/11/2018 ACCT#: VS475673/37 Received Date: 08/11/2018
Sub Phys: Eldridge, Rhys	Family Phys: Mensah, Mira
Oth Phys: Mensah, Mira	Oth Phys:
Oth Phys:	Oth Phys:

Case #: E-55807-54

FINAL DIAGNOSIS

A. TERMINAL ILEUM, BIOPSIES:

- ILEAL MUCOSA SHOWING FOCAL MIXED INFLAMMATION OF THE LAMINA PROPRIA AND A SOLITARY FOCUS OF CRYPTITIS
- NEGATIVE FOR CRYPT ABSCESS FORMATION, GRANULOMAS, DYSPLASIA OR NEOPLASIA

B. COLON, RANDOM BIOPSIES:

- FRAGMENTS OF COLONIC MUCOSA, OVERALL WITHIN NORMAL LIMITS
- NEGATIVE FOR ACTIVE INFLAMMATION, GRANULOMAS, DYSPLASIA OR NEOPLASIA
- NO EVIDENCE OF MICROSCOPIC COLITIS IDENTIFIED

C. RECTUM, RANDOM BIOPSIES:

- FRAGMENTS OF COLONIC MUCOSA, OVERALL WITHIN NORMAL LIMITS
- NEGATIVE FOR ACTIVE INFLAMMATION, GRANULOMAS, DYSPLASIA OR NEOPLASIA

5/xq

SPECIMEN

A. BIOPSY - TERMINAL ILEUM BIOPSIES R/O CROHN'S B. BIOPSY - RANDOM COLON BIOPSIES R/O CROHN'S

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- Eldridge, Rhys

Northview Clinic, Windsor, ON
Patient Name: Nguyen, Zola HRN#: Q897863084
Location: M.QSGAYP Health Card#: 4971549172-ER
Sub Phys: Eldridge, Rhys Family Phys: Mensah, Mira

Case # E-55807-54

C. BIOPSY - RECTAL BIOPSIES R/O CROHN'S

CLINICAL HISTORY

? CROHN'S

GROSS DESCRIPTION

The specimen is received in 3 parts.

A. The specimen, received in formalin, labeled with the patient's identification, Vantage tag and "A terminal ileum", consists of 1 fragment of soft tan tissue (3 mm). Entirely submitted: A1

B. The specimen, received in formalin, labeled with the patient's identification, Vantage tag and "B random colon", consists of 5 fragments of soft tan tissue (2-4 mm). Entirely submitted: B1

C. The specimen, received in formalin, labeled with the patient's identification, Vantage tag and "C rectal", consists of 3 fragments of soft tan tissue (each 2 mm). Entirely submitted: C1

CALL Nov 8, 2018

Signed: <signature on file> 12/11/2018 DR Josefina Obrien Pathologist

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- Eldridge, Rhys

Riverside Medical Centre Northview Clinic Endoscopy Report

PATIENT NAME: Nguyen, Zola — DC Q897863084 F HC: 4971549172-ER 865 Pine Blvd D.O.B. D/M/Y
ADMIT DATE HF Windsor, ON, J3W 6Q0 16/03/1996 08/11/2018 (444) 426-4137 ATT: Costa, Gabriel C D
7 0 5 4 2 6 5 7 4 FP: Costa, Gabriel (colonoscopy/gastroscopy)

Treatment Recommendations: Book for Gast 2-6 wks (call if unwell before then)

Anticoagulation Recommendations: (if applicable) NA

Findings: ? mild crohn's ileitis

Biopsies taken

[image: anatomical diagram of the digestive system with lines pointing to the small intestine]

Colonoscopy/ Gastroscopy Surveillance Interval: ☐ 1 year ☐ 3 years NA ☐ 5 years ☐ Other

Follow-up Plan: ☐ With Family Doctor ☒ With Specialist 2-6 wks

Bowel Prep: ☒ Adequate ☐ Inadequate

Signature Date (dd/mm/yy) _____ [REDACTED-DATE] Physician Name Physician

C D 7 0 5 4 2 6 5 7 4 White copy – Patient Yellow copy – Chart R.ENDORE

Brookfield Medical Centre

Brookfield Medical Centre

556 Fennimore Ave Windsor Ontario T8X 0V9

Administration

Outpatient Services

2nd Floor

Tel: (985) 764-1635 **Fax:** (942) 224-7493

MRI Appointment Notification

Dr.: Nina Lombardi

Patient Name: Zola Nguyen

Booking Date & Time: [REDACTED-DATE]

Please contact your patient with date and time of appointment ***immediately*** to minimize patient inquiries.

PLEASE NOTE CHANGE TO INSTRUCTIONS

For all **MRI - ENTEROGRAPHY** appointments:

- patient must remain **NPO for 3 hours** prior to appointment.
- patient to bring in 2L of either apple or cranberry juice according to his/her preference. Juice may be chilled.
- patient must **arrive 2 hours early** for oral contrast preparation.

If your patient is claustrophobic, the physician is responsible for providing the patient with sedation and making the patient aware that they must bring a driver with them.

Your patient will receive a phone confirmation within 3-5 days prior to their scheduled appointment.

*www.riversidemedicalcentre.ca

Fairlight Medical Centre New Patient Questionnaire [REDACTED-DATE] 11

Name: Zola Nguyen Today's Date: APR 3, 2019 Date of Birth: MAR 16, 1996 Height: 5'3" Weight: 115
Pharmacy: LNEYFWZJ KW 660 EKJEJM Email: zola.nguyen55@westbrookmedicalassociates.ca
Insurance: Private/ ODSP/NONE

List all current medications and their dosage:

- [illegible] finished pred Nov 14th
-
-
-
-

List your Surgical History (and approximate date if known): GALLBLADDER REMOVAL SEP 2016

List your Medical History (and approximate date of initial diagnosis): GALLSTONES Aug 2016 BOWEL OBSTRUCTION AUG 2018

List any medication Allergies: N/A

works @ follow-up in retired

Do you smoke? NO How long? (blank) How many per day? (blank) Do you smoke cannabis(marihuana)? (Yes/No) = No How long? (blank) How much per day? (blank) Do you use any other recreational drugs (Yes/No) = No How many alcoholic drinks do you drink during an average week? one (including wine & beer)

List any family history of the digestive system: (cancer of esophagus, stomach, colon, pancreas, liver, or gallbladder) Colon cancer Gallstones

- uncle w/ Crohns disease -

Family History - of bowel (colon) polyps:

Family History - General: cancer Diabetees

Signature [signature] Date APR 3, 2019

Stomach issues whole life.

Stomach cramps last few year.

Fatigue.

4-10 BM/day (L) diarrhea.

Bloody

Plan - IBD BW

- Start Stelara
- MRI 6 months to assess response
- See [REDACTED-PROVIDER-NAME].

Brookfield Medical Centre

Brookfield Medical Centre

556 Fennimore Ave Windsor Ontario T8X 0V9

Administration

Outpatient Services

2nd Floor

Tel: (985) 764-1635 Fax: (942) 224-7493

MRI Appointment Notification

Dr.: Pablo Dubois

Patient Name: Zola Nguyen

Booking Date & Time: [REDACTED-APPOINTMENT-DATE-AND-TIME]

Please contact your patient with date and time of appointment ***immediately*** to minimize patient inquiries.

PLEASE NOTE CHANGE TO INSTRUCTIONS

For all **MRI -- ENTEROGRAPHY** appointments:

- patient must remain **NPO for 3 hours** prior to appointment.
- patient to bring in 2L of either apple or cranberry juice according to his/her preference. Juice may be chilled.
- patient must **arrive 2 hours early** for oral contrast preparation.

If your patient is claustrophobic, the physician is responsible for providing the patient with sedation and making the patient aware that they must bring a driver with them.

Your patient will receive a phone confirmation within 3-5 days prior to their scheduled appointment.

*www.riversidemedicalcentre.ca

Patient: Nguyen, Zola Birthdate: 1996 Age: 23 Gender: Female OHIP: 5580754235 LT

Referring Doctor: Dr. Pablo Dubois Referrer fax: (266) 817-8598 CC: Mira Mensah ((915) 475-8760)
Modality: X-Ray Procedure Description: Chest PA/LAT-X091 Lpuwrxztw Qhbxmm: 971549 Requested
Date: 08 Apr 2019 10:58

The cardiac silhouette and mediastinal contours are normal. The lungs and pleura are clear. No pneumothorax is seen. The bones are unremarkable.

Impression: Normal study.

Dictated but not read Dictated by: Alden Alvarez Transcribed by: Ethan Marchand

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NAME: Nguyen, Zola SGA: 95-300211 DOB: 1996

PATIENT INFORMATION:

- **Name:** Zola Nguyen (Patient ID: S-7185261564)
- **Preferred Name:**
- **Address:** 313 Glenarm Blvd, Nanaimo, ON, Canada J3W 6Q0
- **Tel:** (283) 952-6505
- **Date of Birth (DD/MM/YYYY):** 16/03/1996 **Gender:** Female
- **Allergies:** NKDA
- **Indication:** Crohn's Disease
- **Secondary Indication:**
- **Weight (KG):** 52.00 **Date of Wt (DD/MM/YYYY):** 10/04/2019
- **Hospital ID:**

PRESCRIBING PHYSICIAN INFORMATION:

- **Name:** Dr. Pablo Dubois
- **Licence Number:**
- **Address:** 662 Victoria St, Nanaimo, ON Y5H 0A2
- **Tel:** (224) 560-8037
- **Pager:**
- **Fax:** (865) 998-7318
- **Ref:** WQ-3084497154
- **Pharmacy Name:** Stonebridge Health Clinic
- **Fax:** (425) 784-7201

PRESCRIBING PHYSICIAN SECTION

Schedule	Starting Week #	Administration	Drug	DIN	Dose	Precision	Frequency	Repeats
Induction	0	Infusion	Stelara	02459671	260 mg	Exactly		
Induction	8	Injection	Stelara	02320681	1 x 90 mg Pre-Filled Syringe	Exactly		
Maintenance	16	Injection	Stelara	02320681	1 x 90 mg Pre-Filled Syringe	Exactly	Every 8 Week(s)	

DURATION: 52 Weeks

This is: ☒ first STELARA order for this patient ☐ OR a renewal ☐ OR a change in prescription

☒ Utilize the Stelara I.V. Recommended Standard Protocol to infuse Stelara I.V ☐ Other Infusion Duration:

PRETREATMENT ORDER

Option 1 ☒ No pre-medications required **Option 2** Please Check desired pretreatment medication(s) administered prior to infusion at clinic (indicate dose/route) ☐ Diphenhydramine (e.g., Benadryl) ____ mg ☐ Acetaminophen ____ mg ☐ Hydrocortisone ____ mg ☐ Dimenhydrinate (e.g., Gravol) ____ mg ☐ Desloratadine ____ mg ☐ Other:

RELEVANT MEDICAL/SURGICAL HISTORY, MEDICATION(S) AND NOTES:

TB Test ☐ Not required **OR** Date Completed: 10/04/2019 **Result:** Negative **CXR** ☐ Not required **OR** Date Completed: 08/04/2019 **Result:** Normal **Hep B** ☐ Not required **OR** Date Completed: 08/04/2019 **Result:** Negative

PRESCRIBER CERTIFICATION I certify that this prescription is an original prescription and will not be reused.

Physician Signature: [signature: Pablo Dubois] Date: Apr 10, 2019 *Effective date.

Fax order to: Emeka Popov **Fax:** (669) 837-3904 672 Main Rd | Barrhaven, Ontario | W0U 5L2 | www.sunnymedfamilypractice.ca © 2014 Lakeshore Specialty Clinic | All trademarks used under license. All other third party trademarks are the property of their respective owner(s).

YP-3002114578

(BIO) JANSSEN ADVANCE®

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	16/03/1996

2. INFUSION CONFIRMATION REPORT

TO: Prescribing Physician:: Pablo Dubois Fax #: (865) 998-7318

FROM: Infusion Location: Harbour Medical Centre Contact Person: Fax #: Phone #:

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: (mg, Frequency, and Route)

4. Crestwood Medical Group® CLINIC AND COORDINATOR INFORMATION

Name of Crestwood Medical Group Clinic: Harbour Medical Centre Phone #: (852) 594-7808

Crestwood Medical Group® Coordinator Name: Emeka Popov Fax #: (669) 837-3904

5. INFUSION INFORMATION

Stelara Dose Given: Weight 52.00kg /114.64 lbs 260.00 mg exact dose Induction Dose: Yes [X] No []

Date of Infusion:	Lot #	Infusion Frequency:	Next Infusion Scheduled
25/04/2019	IFS0700 05/2020 x 2	q 8 week	20/06/2019
(DD/MM/YYYY)			(DD/MM/YYYY)

TDM Serum Draw Completed : Not requested

PREMEDICATION	PRESCRIBED	ADMINISTERED
	DOSE	ROUTE

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Lakeshore Specialty Clinic? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
08/04/2019	03/04/2019	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician:

Name of Infusion Nurse: Emeka Popov

Infusion Nurse's Signature/Date:

(DD/MM/YY)

Remicade® INFLIXIMAB | Simponi® IV golimumab for infusion | Stelara® ustekinumab

Lakeshore Specialty Clinic Ridgeway Family Health | Barrhaven, ON | W0U 5L2 |
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BABRXXXXXXX

Janssen

Highpark Health Centre Highpark Health Centre

Post-injection Feedback Report (For referring physician's review)

Treatment no. GD-1457868978

TO:	CONTACT:
------------	-----------------

Prescribing Physician: Pablo Dubois Fax #: (865) 998-7318

Highpark Health Centre Coordinator Name: Emeka Popov Phone #: (726) 651-9832 Fax #: (669) 837-3904

1. PATIENT INFORMATION

Last Name: Nguyen First Name: Zola Date of birth: (DD/MM/YYYY) 16/03/1996

2. INJECTION INFORMATION

Medication: Stelara Dose: 90 mg Date of Injection: (DD/MM/YYYY) 20/06/2019 Injection performed at: Westbrook Medical Associates Was there an adverse event? No

3. NEXT INJECTION

Next Date of Injection: (DD/MM/YYYY) 15/08/2019 Next injection to be performed at: Westbrook Medical Associates

To be printed and faxed to prescribing physician within 48 hrs

Tremfya™ (guselkumab) Simponi® golimumab Stelara® ustekinumab

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QWBUPLFJPLT

Highpark Health Centre

2019/06/24 10:12:28 1 /1

Birchwood Care Clinic SGC Accredited LAB LAB Accrédité CCN TM

Lab ID: Sunnymede Family Practice Highpark Health Centre External Ref. No.: 8302782

Prescriber

- **Name:** Pablo Dubois
- **Clinic:** Fairlight Medical Centre (Maple Health Clinic 2)
- **Address:** 134 Brookmere Blvd Nanaimo, ON Y5H 0A2
- **Telephone:** 881.491.2872
- **Fax:** (251) 680-8660

Patient

- **Name:** Nguyen, Zola
- **Date of birth:** 1996-03-16
- **Age:** 23
- **Sex:** F
- **Health Ins.:** 3576963291

Biochemistry

Analysis	Specimen	Result	Reference value	Unit	Status
Calprotectin	Stool	360	100	µg/g	

Calprotectin Level

[image of graph showing Calprotectin Level of 360 µg/g on [REDACTED-DATE]]

Collection date	Result (µg/g)
2019-06-16	360

Interpretation: Active inflammation in the gastrointestinal tract. It is recommended to order additional analyses and to optimize the curative treatment under the supervision of medical specialists.

Note: The cut-off level suggested for adults (100 µg/g) can also be used for children aged 4 to 17 years regardless of sex.

Method: Reference values: Normal: < 100 µg/g Moderate inflammation: ≥ 100 - ≤ 250 µg/g Active inflammation: > 250 µg/g

Reference: Bressler B. et al. Clinicians' guide to the use of fecal calprotectin to identify and monitor disease activity in inflammatory bowel disease. Can J Gastroenterol Hepatol. 2015 29(7):369-72.

Comments:

[Signature] Esme Zhang, Ph.D, DEPD, CSPQ Clinical Biochemist

Date Collected	Date Received	Partial report	Completed report	Revised report
2019-06-16	2019-06-17	-	2019-06-24	-

Highpark Health Centre 2

Post-injection Feedback Report (For referring physician's review)

Treatment no. GD-1457868978

TO:	CONTACT:
Prescribing Physician: Pablo Dubois	Highpark Health Centre Coordinator Name: Emeka Popov
Fax #: (865) 998-7318	Phone #: (726) 651-9832 Fax #: (669) 837-3904

1. PATIENT INFORMATION

Last Name: Nguyen First Name: Zola Date of birth: (DD/MM/YYYY): 16/03/1996

2. INJECTION INFORMATION

Medication: Stelara Dose: 90 mg Date of Injection: 15/08/2019 (DD/MM/YYYY) Injection performed at: Westbrook Medical Associates Was there an adverse event? No

3. NEXT INJECTION

Next Date of Injection: 10/10/2019 (DD/MM/YYYY) Next injection to be performed at: Westbrook Medical Associates

To be printed and faxed to prescribing physician within 48 hrs

*Tremfya™ (guselkumab) *Simponi® golimumab *Stelara® ustekinumab

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QWBUPLFJPLT

Highpark Health Centre

Riverside Medical Centre 3 SCC Accredited LAB Accrédité CCN TM

Lab ID: Northview Clinic 2 Highpark Health Centre External Ref. No.: 2567087

Prescriber Name: Pablo Dubois Clinic: Brookfield Medical Centre 2 Address: 479 Juniper St Nanaimo, ON Y5H 0A2 Telephone: 881.491.2872 Fax: (251) 680-8660

Patient Name: Nguyen, Zola Date of birth: 1996-03-16 Age: 23 Sex: F Health Ins.: 3576963291

Biochemistry

Analysis	Specimen	Result	Reference value	Unit	Status
Calprotectin	Stool	133	<100	µg/g	

Calprotectin Level

[image: Line graph showing calprotectin levels over time. Y-axis is µg/g from 0 to 600. X-axis has two points labeled [REDACTED-DATE] and [REDACTED-DATE]. Data points: 2019-06-16 = 360, 2019-08-12 = 133. Horizontal reference lines at 100 (Moderate inflammation) and 250 (Active inflammation).]

Collection date	Result (µg/g)
2019-06-16	360
2019-08-12	133

Interpretation: Possible inflammation (low intensity inflammation may be caused by non-steroidal anti-inflammatory drugs or NSAIDs, non-severe diverticulitis or inflammatory bowel disease in remission phase). To confirm the absence or presence of inflammation, it is recommended to repeat the fecal calprotectin analysis and order complementary analyses (cross sectional imaging, colonoscopy or videocapsule endoscopy).

Note: The cut-off level suggested for adults (100 µg/g) can also be used for children aged 4 to 17 years regardless of sex.

Method: Reference values: Normal: < 100 µg/g Moderate inflammation: ≥ 100 - ≤ 250 µg/g Active inflammation: > 250 µg/g

Reference: Bressler B. et al. Clinicians' guide to the use of fecal calprotectin to identify and monitor disease activity in inflammatory bowel disease. Can J Gastroenterol Hepatol. 2015 29(7):369-72.

Comments:

Esme Zhang, Ph.D, DEPD, CSPQ Clinical Biochemist

Date Collected	Date Received	Partial report	Completed report	Revised report
2019-08-12	2019-08-13	-	2019-08-18	-

810 Wellington Ave, Edmonton (QC) Canada X8W 1A2 T 640.721.9849 F 465.536.1661

Glenmore Specialist Centre Prebiologic Treatment Checklist

clinic or home provider name: Crestwood Medical Group 2 Date: [REDACTED-DATE] (DD/MM/YY)

PATIENT-SPECIFIC INFORMATION

1.1 Patient name: Zola Nguyen Patient date of birth: 1996 (DD/MM/YY) Patient weight today: ~~kg~~ 49 kg
Patient sex: ☐ Male ☒ Female

1.2 Vital signs BP: ~~mmHg~~ 120/80 S 95/78 Pulse: ~~bpm~~ 63 Resp. rate: ~~Text~~ 16 Temp.: ~~Degrees~~ 36.6 °C

1.3 Allergies: ☐ Yes ☐ No ☐ RPC* If yes, describe or list (e.g., drug, mouse, latex, other?):

1.4 Documented acute reaction†: ☐ Yes ☐ No If yes, please specify: ☐ REMICADE® infusion ☐ STELARA® injection ☐ Entyvio IV ☐ SIMPONI® I.V. infusion ☐ SIMPONI® injection ☐ Inflectra IV ☐ Renflexis

1.5 Last ☐ REMICADE® infusion ☒ STELARA® injection ☐ Inflectra IV ☐ SIMPONI® I.V. infusion ☐ SIMPONI® injection ☐ STELARA Date: [REDACTED-DATE] DD/MM/YYYY ☐ Renflexis ☐ Entyvio IV
Dose: ~~mg~~ 90

CURRENT DRUG: ☐ REMICADE® ☐ SIMPONI® I.V. ☐ SIMPONI® ☒ STELARA®

1.6 Indication: ~~Text~~ ☐ Entyvio IV ☐ Renflexis ☐ Inflectra IV Notes: ~~Text~~ Please refer to the respective product monographs for full indications and safety information.

1.7 Dose to administer today: ~~Text~~ mg/kg or ~~Text~~ mg

1.8 Total to administer: ~~Text~~ mg Checked against REMICADE® /SIMPONI® I.V. infusion or SIMPONI® /STELARA® injection medical order/prescription: Biologic: ~~Text~~

1.9 Change in current medications (**Other than Biologic**) ☐ Yes ☒ No

PATIENT PRESCREENING QUESTIONNAIRE

	Yes	No	RPC*	If yes, please explain
1. Since your last REMICADE® / SIMPONI® I.V. infusion or SIMPONI® /STELARA® or other Biologic, have you been hospitalized, had surgery, or had to go to the emergency ward?	☐	☒	☐	
2. Is there any planned surgery related or not to your disease scheduled in the next 2 months?‡	☐	☒	☐	
3. Since your last Biologic, have you had any vaccinations?	☐	☒	☐	

	Yes	No	RPC*	If yes, please explain
4. Are you planning to receive any vaccinations in the near future?†	☐	☒	☐	[REDACTED-DATE] - pneumonia
5. Are you currently breastfeeding?	☐	☒	☐	
6. Do you think you are pregnant?	☐	☒	☐	
7. Have you had, or do you currently have, a fever or flu-like symptoms?	☒	☐	☐	[REDACTED-DATE]
8. Do you currently have any active or recurring infections?	☒	☐	☐	
9. Have you taken any antibiotics since your last Biologic injection, or are you currently taking any antibiotics?	☒	☐	☐	Has had strep, last day for antibiotics is [REDACTED-DATE] - spoke to Dr. Dubois on [REDACTED-DATE] ok to have Stelara.
10. Have you travelled to any TB-endemic areas and/or been exposed to TB since your last Biologic?	☐	☐	☐	

Other comments (patient general/normal appearance): ~~Text~~ Pt reports has had strep x 1 month, on antibiotics ~~Text~~

Nurse's signature: Agnes Arnold Nurse Initials: MD Date: 15/08/2019 (DD/MM/YY)

A/E reported to sponsoring company? ☐ Yes ☒ Not applicable

- RPC = record of physician consent; prescribing physician was contacted, and documented consent from prescribing physician was confirmed for treatment indication prescribed. † As documented in the patient's chart at the Cedar Specialist Group 2/home provider. ‡ If patient answers "Yes", this must be documented on the Post-Infusion Feedback Report (REMICADE® and SIMPONI® I.V. patients only).

Glenmore Specialist Centre 2 Date: 15/08/2019

PATIENT NAME: Zola Nguyen DOB: Dr. Dubois S-7185261564 Crohn's (/) or Colitis () DRUG: Stelara 90mg SC inject Last infusion date: Shortened Standard Immunosuppressants:

LABS (/)* yes () no Allergies: (TDM) (/) yes ()* no PRE MEDS () yes (/) no → → Drugs:

Weight: 90 49 kg. Initial Vitals: Questionnaire: AE (/) yes () no

IV Insertion: 1215 Location: (L) A/C for BW (L) arm for Stelara Inj.

DRUG START @ LOT # JBSOBMD Expiry Date: JA 2022

Time	Rate	Vitals

Time	Rate	Vitals
		[handwritten diagonal line through table with initials 'A']

Drug completed @

Infusion tolerated well NA Adverse Event _____

Last Labs: [REDACTED-DATE] Next Appt: [REDACTED-DATE] Last MD appt: [REDACTED-DATE] Stelara Inj only + BW Next MD visit: ?

Agnes Arnold RN

Glenmore Specialist Centre Prebiologic Treatment Checklist

clinic or home provider name: Crestwood Medical Group 2 Date: 2019-Aug-15 (DD/MM/YY)

PATIENT-SPECIFIC INFORMATION

1.1 Patient name: Zola Nguyen Patient date of birth: 1965 (DD/MM/YY) Patient weight today: 88 kg kg Patient sex: ☒ Male ☐ Female

1.2 Vital signs BP: tt/tt 147 / 91 Pulse: bpm 66 Resp. rate: Text 18 Temp.: Degrees 36.7 °C

1.3 Allergies: ☐ Yes ☒ No ☐ RPC* If yes, describe or list (e.g., drug, mouse, latex, other?):

1.4 Documented acute reaction†: ☐ Yes ☐ No If yes, please specify: ☒ REMICADE® infusion ☐ STELARA® injection ☐ Entyvio IV ☐ SIMPONI® I.V. infusion ☐ SIMPONI® injection ☐ Inflectra IV ☐ Renflexis

1.5 Last ☒ REMICADE® infusion ☐ STELARA® injection ☐ Inflectra IV ☐ SIMPONI® I.V. infusion ☐ SIMPONI® injection ☐ STELARA Date: [REDACTED-DATE] DD/MM/YYYY ☐ Renflexis ☐ Entyvio IV Dose: mg 900

CURRENT DRUG: ☐ REMICADE® ☐ SIMPONI® I.V. ☐ SIMPONI® ☐ STELARA® 1.6 Indication: Text ☐ Entyvio IV ☐ Renflexis ☐ Inflectra IV Notes: Text Please refer to the respective product monographs for full indications and safety information.

1.7 Dose to administer today: Text mg/kg or Text mg 1.8 Total to administer: 900 Text mg Checked against REMICADE® / SIMPONI® I.V. infusion or SIMPONI® / STELARA® injection medical order/prescription: Biologic: Text

1.9 Change in current medications (Other than Biologic) ☐ Yes ☒ No

PATIENT PRESCREENING QUESTIONNAIRE

	Yes	No	RPC*	If yes, please explain
1. Since your last REMICADE® / SIMPONI® I.V. infusion or SIMPONI® / STELARA® or other Biologic, have you been hospitalized, had surgery, or had to go to the emergency ward?	☐	☒	☐	
2. Is there any planned surgery related or not to your disease scheduled in the next 2 months?‡	☐	☒	☐	
3. Since your last Biologic, have you had any vaccinations?	☐	☒	☐	
4. Are you planning to receive any vaccinations in the near future?‡	☐	☒	☐	
5. Are you currently breastfeeding?	☐	☒	☐	
6. Do you think you are pregnant?	☐	☒	☐	
7. Have you had, or do you currently have, a fever or flu-like symptoms?	☐	☒	☐	
8. Do you currently have any active or recurring infections?	☐	☒	☐	
9. Have you taken any antibiotics since your last Biologic injection, or are you currently taking any antibiotics?	☐	☒	☐	
10. Have you travelled to any TB-endemic areas and/or been exposed to TB since your last Biologic?	☐	☒	☐	

Other comments (patient general/normal appearance): Text Pt. appears well, reports feeling well recently

Nurse's signature: Agnes Arnold RN Nurse Initials: MD Date: DD-MM-YYYY 15/08/2019 (DD/MM/YY)

A/E reported to sponsoring company? ☐ Yes ☒ Not applicable

- RPC = record of physician consent; prescribing physician was contacted, and documented consent from prescribing physician was confirmed for treatment indication prescribed. † As documented in the patient's chart at the Cedar Specialist Group 2/home provider. ‡ If patient answers "Yes", this must be documented on the Post-Infusion Feedback Report (REMICADE® and SIMPONI® I.V. patients only).

Glenmore Specialist Centre 2 Date: 15/08/2019

PATIENT NAME: Zola Nguyen DOB: 21/01/1965 Dr. Dubois C-06919729235 Crohn's (/) or Colitis ()

DRUG: REMICADE 900 Last infusion date: 04/07/2019 [Shortened] Q6weeks Standard

Immunosuppressants:

LABS (/) yes () no Allergies: TDM () yes (/) no PRE MEDS () yes (/) no -> -> Drugs:

Weight: 88 Kg Initial Vitals: 147/91 18 66 36.7 Questionnaire: AE (/) yes () no

IV Insertion: 0830 Location: (/) hand

DRUG START @ 0900 LOT # JCM 69015 X 9 Expiry Date: Feb 2022

Time	Rate	Vitals
/ 0900	80	
X 0915	260	128/82 67-18 36^9 0915
		140/80 -68-18 36^9 0945
		- States feeling well -
1016		130/87 65 18 36^3

Drug completed @

Infusion tolerated well YES Adverse Event O

Last Labs: 15/08/2019 Next Appt: Last MD appt: [REDACTED-DATE] [REDACTED-DATE] Next MD visit: [REDACTED-DATE] @ 0830.

Agnes Arnold RegN.

Riverside Medical Centre 3

SGC Accredited LAB LAB Accrédité CCN TM

Lab ID: 7863-084497 Highpark Health Centre External Ref. No.: 1966736

Prescriber Name: Pablo Dubois Clinic: Brookfield Medical Centre 2 Address: 112 Aldergrove Ave
Telephone: 812.337.5616 Fax: 420.616.3265

Patient Name: Nguyen, Zola Date of birth: 1996-03-16 Age: 23 Sex: F Health Ins.: 3576963291

Note: * Ustekinumab testing procedure (Reflex Testing): Ustekinumab drug levels and antibodies are tested using a stepwise, reflex procedure. Ustekinumab drug levels are tested initially and reported. If the Ustekinumab drug level is below the limit of quantification ($\leq 0.625 \mu\text{g/mL}$) then anti-Ustekinumab antibody levels will be tested and reported.

Biochemistry

Analysis	Specimen	Result	Reference value	Unit	Status
Ustekinumab Drug Level*	Serum	6.953		$\mu\text{g/mL}$	

Interpretation: Therapeutic level

Anti-Ustekinumab antibodies will not be tested

Method: Reference cut-points defined by a consensus of gastroenterologists, applicable in the context of inflammatory bowel diseases:

Subtherapeutic level: $< 1 \mu\text{g/mL}$ Therapeutic level: $1 - 10 \mu\text{g/mL}$ Supratherapeutic level: $> 10 \mu\text{g/mL}$

Therapeutic drug monitoring for Ustekinumab may be used in addition to the patient's clinical evaluation to guide the optimization of treatment. The performance characteristics of this test were validated by Riverside Medical Centre 3. This test is not licensed by the Therapeutic Products Directorate (TPD) of Health Canada.

Comments:

[signature] Esme Zhang, Ph.D, DEPD, CSPQ Clinical Biochemist

Date Collected	Date Received	Partial report	Completed report	Revised report
2019-08-15	2019-08-16	-	2019-08-20	-

514 Cedar St T 653.565.9295 F 866.340.9414

Highpark Health Centre 2

Post-injection Feedback Report (For referring physician's review)

Treatment no. GD-1457868978

TO:	CONTACT:
Prescribing Physician: Pablo Dubois	Highpark Health Centre Coordinator Name: Emeka Popov
Fax #: (865) 998-7318	Phone #: (726) 651-9832 Fax #: (669) 837-3904

1. PATIENT INFORMATION

Last Name: Nguyen First Name: Zola Date of birth: (DD/MM/YYYY) 16/03/1996

2. INJECTION INFORMATION

Medication: Stelara Dose: 90 mg Date of Injection: 10/10/2019 (DD/MM/YYYY) Injection performed at: Westbrook Medical Associates Was there an adverse event? No

3. NEXT INJECTION

Next Date of Injection: 05/12/2019 (DD/MM/YYYY) Next injection to be performed at: Westbrook Medical Associates

To be printed and faxed to prescribing physician within 48 hrs

Tremfya™ (guselkumab) | Simponi® golimumab | Stelara® ustekinumab | Highpark Health Centre
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| Highpark Health Centre

Glenmore Specialist Centre Prebiologic Treatment Checklist

clinic or home provider name: Crestwood Medical Group 2 Date: 2019-Oct-10 mm (DD/MM/YY)

PATIENT-SPECIFIC INFORMATION

1.1 Patient name: Zola Nguyen **Patient date of birth:** 1996 (DD/MM/YY) **Patient weight today:** 49.5 kg
Patient sex: ☐ Male ☒ Female

1.2 Vital signs BP: 105/68 tt/tt **Pulse:** 72 bpm **Resp. rate:** 18 Text **Temp.:** 36.7 Degrees °C

1.3 Allergies: ☐ Yes ☒ No ☐ RPC* If yes, describe or list (e.g., drug, mouse, latex, other?): (blank)

1.4 Documented acute reaction†: ☐ Yes ☒ No If yes, please specify: ☐ REMICADE® infusion ☐ STELARA® injection ☐ Entyvio IV ☐ SIMPONI® I.V. infusion ☐ SIMPONI® injection ☐ Inflectra IV ☐ Renflexis

1.5 Last ☐ REMICADE® infusion ☐ STELARA® injection ☐ Inflectra IV ☐ SIMPONI® I.V. infusion ☐ SIMPONI® injection ☒ STELARA **Date:** 15/08/2019 DD/MM/YYYY ☐ Renflexis ☐ Entyvio IV **Dose:** 90 mg

CURRENT DRUG: ☐ REMICADE® ☐ SIMPONI® I.V. ☐ SIMPONI® ☒ STELARA®

1.6 Indication: Tex Crohn's ☐ Entyvio IV ☐ Renflexis ☐ Inflectra IV **Notes:** Text Please refer to the respective product monographs for full indications and safety information.

1.7 Dose to administer today: Text 90 mg/kg or 90 Text mg

1.8 Total to administer: 90 Text mg **Checked against REMICADE® /SIMPONI® I.V. infusion or SIMPONI® /STELARA® injection medical order/prescription:** **Biologic:** Text YES

1.9 Change in current medications (Other than Biologic) ☐ Yes ☒ No

PATIENT PRESCREENING QUESTIONNAIRE

	Yes	No	RPC*	If yes, please explain
1. Since your last REMICADE® / SIMPONI® I.V. infusion or SIMPONI® / STELARA® or other Biologic, have you been hospitalized, had surgery, or had to go to the emergency ward?	☐	☒	☐	recent resolved
2. Is there any planned surgery related or not to your disease scheduled in the next 2 months?‡	☐	☒	☐	Cold Saw FD
3. Since your last Biologic, have you had any vaccinations?	☐	☒	☐	No symptoms
4. Are you planning to receive any vaccinations in the near future?‡	☐	☒	☐	now

	Yes	No	RPC*	If yes, please explain
5. Are you currently breastfeeding?	☐	☒	☐	No change
6. Do you think you are pregnant?	☐	☒	☐	in Medication
7. Have you had, or do you currently have, a fever or flu-like symptoms?	☐	☒	☐	
8. Do you currently have any active or recurring infections?	☐	☒	☐	
9. Have you taken any antibiotics since your last Biologic injection, or are you currently taking any antibiotics?	☐	☒	☐	
10. Have you travelled to any TB-endemic areas and/or been exposed to TB since your last Biologic?	☐	☒	☐	

Other comments (patient general/normal appearance): Text

Nurse's signature: [signature] Nurse Initials: [initials] Date: 10/10/2019 (DD/MM/YY)

A/E reported to sponsoring company? ☐ Yes ☒ Not applicable

* RPC = record of physician consent; prescribing physician was contacted, and documented consent from prescribing physician was confirmed for treatment indication prescribed. † As documented in the patient's chart at the Cedar Specialist Group 2/home provider. ‡ If patient answers "Yes", this must be documented on the Post-Infusion Feedback Report (REMICADE® and SIMPONI® I.V. patients only).

Glenmore Specialist Centre 2 Nursing Note

DATE: [REDACTED-DATE] PATIENT NAME: Nguyen, Zola DOB: 1996 Dr. Dubois Kian Farrow Crohn's ([X]) or Colitis () DRUG: Stelara Injection Last infusion date: 15/08/2019 Shortened Standard Immunosuppressants: LABS () yes ([X]) no Allergies: NKDA TDM () yes ([X]) no PRE MEDS () yes ([X]) no → → Drugs: Weight: 49.5 Initial Vitals: 36.7 72-18 105/68 Questionnaire: AE () yes () no IV Insertion @ [illegible] Location: Lot # JDS0P MF Expiry date 03 2022 DRUG START @

Time	Rate	Vitals
		36.7-72-18 105/68
		Stelara 90 mg given to left deltoid [illegible]
		[illegible]

Drug completed @ Infusion tolerated well yes A/E 0 IV D/C'D with catheter intact yes Patient left walking alone in satisfactory condition, no complaints yes Post infusion discharge instructions given yes Last Labs: [REDACTED-DATE] Next Appt: Last MD appt: [REDACTED-DATE] [REDACTED-DATE] @ 1330 Next MD visit: ? Nurse Emeka Popov Signature Emeka Popov Date [REDACTED-DATE]

Post-injection Feedback Report

(For referring physician's review)

Treatment no. GD-1457868978

TO:	CONTACT:
Prescribing Physician: Pablo Dubois	Highpark Health Centre Coordinator Name: Emeka Popov
Fax #: (865) 998-7318	Phone #: (726) 651-9832 Fax #: (669) 837-3904

1. PATIENT INFORMATION

Nguyen	Zola	1996
Last Name	First Name	Date of birth: (DD/MM/YYYY)

2. INJECTION INFORMATION

Medication: Stelara **Dose:** 90 mg **Date of Injection:** 05/12/2019
(DD/MM/YYYY)

Injection performed at: Westbrook Medical Associates **Was there an adverse event?** No

3. NEXT INJECTION

Next Date of Injection: 30/01/2020 **Next injection to be performed at:** Westbrook Medical Associates
(DD/MM/YYYY)

To be printed and faxed to prescribing physician within 48 hrs

![Tremfya logo] Tremfya™ (guselkumab) ![Simponi logo] Simponi® golimumab ![Stelara logo] Stelara®
ustekinumab

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QWBUPLFJPLT ![Innovative Medicines Canada logo] ![Highpark Health Centre logo]

Glenmore Specialist Centre Prebiologic Treatment Checklist

clinic or home provider name: Crestwood Medical Group 2 Date: 2019-Dec-04 (DD/MM/YY)

PATIENT-SPECIFIC INFORMATION

1.1 Patient name: Zola Nguyen Patient date of birth: 1996 (DD/MM/YY) Patient weight today: 52 kg
Patient sex: ☐ Male ☒ Female

1.2 Vital signs BP: tt/tt = 108/76 Pulse: bpm = 68 Resp. rate: Text = 18 Temp.: Degrees = 36.3 °C

1.3 Allergies: ☐ Yes ☒ No ☐ RPC* If yes, describe or list (e.g., drug, mouse, latex, other?): (blank)

1.4 Documented acute reaction†: ☐ Yes ☒ No If yes, please specify: ☐ REMICADE® infusion ☐ STELARA® injection ☐ Entyvio IV ☐ SIMPONI® I.V. infusion ☐ SIMPONI® injection ☐ Inflectra IV ☐ Renflexis

1.5 Last ☐ REMICADE® infusion ☒ STELARA® injection ☐ Inflectra IV ☐ SIMPONI® I.V. infusion ☐ SIMPONI® injection ☒ STELARA Date: DD/MM/YY = Oct 10, 2019 ☐ Renflexis ☐ Entyvio IV Dose: mg = 90

CURRENT DRUG: ☐ REMICADE® ☐ SIMPONI® I.V. ☐ SIMPONI® ☒ STELARA®

1.6 Indication: Text = CD ☐ Entyvio IV ☐ Renflexis ☐ Inflectra IV Notes: Text = (blank) Please refer to the respective product monographs for full indications and safety information.

1.7 Dose to administer today: Text = 90 mg/kg or 90 Text mg

1.8 Total to administer: 90 Text mg Checked against REMICADE®/SIMPONI® I.V. infusion or SIMPONI® /STELARA® injection medical order/prescription: Biologic: Text

1.9 Change in current medications (Other than Biologic) ☐ Yes ☒ No

PATIENT PRESCREENING QUESTIONNAIRE

	Yes	No	RPC*	If yes, please explain
1. Since your last REMICADE® / SIMPONI® I.V. infusion or SIMPONI® / STELARA® or other Biologic, have you been hospitalized, had surgery, or had to go to the emergency ward?	☐	☒	☐	
2. Is there any planned surgery related or not to your disease scheduled in the next 2 months?‡	☐	☒	☐	
3. Since your last Biologic have you had any vaccinations?	☐	☒	☐	

	Yes	No	RPC*	If yes, please explain
4. Are you planning to receive any vaccinations in the near future?†	☒	☐	☐	4) flu vaccine
5. Are you currently breastfeeding?	☐	☒	☐	
6. Do you think you are pregnant?	☐	☒	☐	
7. Have you had, or do you currently have, a fever or flu-like symptoms?	☐	☒	☐	
8. Do you currently have any active or recurring infections?	☐	☒	☐	
9. Have you taken any antibiotics since your last Biologic injection, or are you currently taking any antibiotics?	☐	☒	☐	
10. Have you travelled to any TB-endemic areas and/or been exposed to TB since your last Biologic?	☐	☒	☐	

Other comments (patient general/normal appearance): Text = (blank)

Nurse's signature: [signature] Nurse Initials: JT Date: DD-MM-YYYY = 05/12/2019 A/E reported to sponsoring company? ☐ Yes ☒ Not applicable

* RPC = record of physician consent; prescribing physician was contacted, and documented consent from prescribing physician was confirmed for treatment indication prescribed. † As documented in the patient's chart at the Cedar Specialist Group 2/home provider. ‡ If patient answers "Yes", this must be documented on the Post-Infusion Feedback Report (REMICADE® and SIMPONI® I.V. patients only).

Glenmore Specialist Centre 2 Nursing Note DATE: [REDACTED-DATE]

PATIENT NAME: Zola Nguyen DOB: 1996 Dr. Pablo Dubois L-2789 089 467 Crohn's (☐) or Colitis (☐)
 DRUG: Stelara 90mg Last infusion date: [REDACTED-DATE] Shortened (blank) Standard (blank) Q8W
 Immunosuppressants: MT LABS (☐) yes (L) no Allergies: NKDA TDM (☐) yes (L) no PRE MEDS (☐) yes (L) no
 \$rightarrow\$ \$rightarrow\$ Drugs: N/A

Weight: 52 Initial Vitals: Questionnaire: AE (☐) yes (0) no

IV Insertion @ MT Location: N/A Lot # JFS1YMC Expiry date 05/2022 DRUG START @ (blank)

Time	Rate	Vitals
		S/C injection of Stelara
		to (R) upper arm
		by nurse (myself)
		Pt states unable to
		do own S/C

Time	Rate	Vitals
		So on maintenance
		injections at GI clinic

Drug completed @ 1330 Infusion tolerated well yes A/E NO JR IV D/C'D with catheter intact yes Patient left walking alone in satisfactory condition, no complaints yes. Post infusion discharge instructions given yes
 Last Labs: TODAY Next Appt: Jan 30, 2020 Last MD appt: APR 3, 2019 Next MD visit: NONE BOOKED
 Nurse Ortega Signature Zhang. Date Dec 5, 2019 10 AM

Post-injection Feedback Report

(For referring physician's review)

Treatment no. MQ-7209530021

TO:	CONTACT:
Prescribing Physician: Pablo Dubois	Highpark Health Centre Coordinator Name: Emeka Popov
Fax #: (865) 998-7318	Phone #: (726) 651-9832 Fax #: (669) 837-3904

1. PATIENT INFORMATION

Last Name: Nguyen

First Name: Zola

Date of birth: (DD/MM/YYYY): 1996

2. INJECTION INFORMATION

Medication: Stelara

Dose: 90 mg

Date of Injection: (DD/MM/YYYY): 30/01/2020

Injection performed at: Westbrook Medical Associates

Was there an adverse event? No

3. NEXT INJECTION

Next Date of Injection: (DD/MM/YYYY): 26/03/2020

Next injection to be performed at: Westbrook Medical Associates

To be printed and faxed to prescribing physician within 48 hrs

Tremfya™ (guselkumab) | Simponi® golimumab | Stelara® ustekinumab

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Highpark Health Centre

Glenmore Specialist Centre Prebiologic Treatment Checklist

clinic or home provider name: Crestwood Medical Group 2 Date: 2020-Jan-29 [REDACTED-DATE]
(DD/MM/YY)

PATIENT-SPECIFIC INFORMATION

1.1 Patient name: Zola Nguyen **Patient date of birth:** 1996 (DD/MM/YY) **Patient weight today:** kg 48.5 kg **Patient sex:** ☐ Male ☒ Female

1.2 Vital signs BP: tt/tt 108/70 Pulse: bpm 64 Resp. rate: Text 18 Temp.: Degrees 36.3 °C

1.3 Allergies: ☐ Yes ☒ No ☐ RPC* If yes, describe or list (e.g., drug, mouse, latex, other?): NKDA

1.4 Documented acute reaction†: ☐ Yes ☒ No If yes, please specify: ☐ REMICADE® infusion ☐ STELARA® injection ☐ Entyvio IV ☐ SIMPONI® I.V. infusion ☐ SIMPONI® injection ☐ Inflectra IV ☐ Renflexis

1.5 Last ☐ REMICADE® infusion ☒ STELARA® injection ☐ Inflectra IV ☐ SIMPONI® I.V. infusion ☐ SIMPONI® injection ☐ STELARA IV Date: [REDACTED-DATE] DD/MM/YYYY ☐ Renflexis ☐ Entyvio IV Dose: mg 90

CURRENT DRUG: ☐ REMICADE® ☐ SIMPONI® I.V. ☐ SIMPONI® ☒ STELARA® **1.6 Indication:** Text Crohn's ☐ Entyvio IV ☐ Renflexis ☐ Inflectra IV **Notes:** Text Please refer to the respective product monographs for full indications and safety information.

1.7 Dose to administer today: STELARA Text mg/kg or 90 Text mg

1.8 Total to administer: 90 Text mg **Checked against REMICADE® / SIMPONI® I.V. infusion or SIMPONI® / STELARA® injection medical order/prescription:** **Biologic:** Text yes

1.9 Change in current medications (Other than Biologic) ☐ Yes ☒ No

PATIENT PRESCREENING QUESTIONNAIRE

	Yes	No	RPC*	If yes, please explain
1. Since your last REMICADE® / SIMPONI® I.V. infusion or SIMPONI® / STELARA® or other Biologic, have you been hospitalized, had surgery, or had to go to the emergency ward?	☒	☐	☐	Clinic re Ural
2. Is there any planned surgery related or not to your disease scheduled in the next 2 months?‡	☐	☒	☐	cold.
3. Since your last Biologic have you had any vaccinations?	☐	☒	☐	2 weeks ago

	Yes	No	RPC*	If yes, please explain
4. Are you planning to receive any vaccinations in the near future?‡	☐	☒	☐	[blank]
5. Are you currently breastfeeding?	☐	☒	☐	@ Abxs mostly
6. Do you think you are pregnant?	☐	☒	☐	resolved
7. Have you had, or do you currently have, a fever or flu-like symptoms?	☐	☒	☐	[blank]
8. Do you currently have any active or recurring infections?	☐	☒	☐	@ flare
9. Have you taken any antibiotics since your last Biologic injection, or are you currently taking any antibiotics?	☐	☒	☐	[blank]
10. Have you travelled to any TB-endemic areas and/or been exposed to TB since your last Biologic?	☐	☒	☐	New Medications

Other comments (patient general/normal appearance): Text

Nurse's signature: Emeka Popov Nurse Initials: F Date: DD-MM-YYYY [REDACTED-DATE] (DD/MM/YY)

A/E reported to sponsoring company? ☐ Yes ☒ Not applicable

- RPC = record of physician consent; prescribing physician was contacted, and documented consent from prescribing physician was confirmed for treatment indication prescribed. ‡ As documented in the patient's chart at the Cedar Specialist Group 2/home provider. § If patient answers "Yes", this must be documented on the Post-Infusion Feedback Report (REMICADE® and SIMPONI® I.V. patients only).

Glenmore Specialist Centre 2 Nursing Note DATE: [REDACTED-DATE]

PATIENT NAME: Zola Nguyen, Dr. Dubois S-7185261564 DOB: 1996 Crohn's (☐) or Colitis (☐) DRUG: STELARA 90 mg Shortened Standard Q8W Last infusion date: [REDACTED-DATE] Immunosuppressants:

LABS () yes (☐) no TDM () yes (☐) no PRE MEDS () yes (☐) no → → Allergies: NKDA Drugs:

Weight: 48.5 Initial Vitals: 36° 64. 108/70 Questionnaire: AE () yes (☐) no

IV Insertion @ NA Location: Lot # JG S1GMD DRUG START @ Expiry date 06. 2022.

Time	Rate	Vitals
		Decl. have cold symptoms
		in last 2 weeks
		- is mostly resolved
		Ø fever Ø Abx's
		- SQ Stelara to

Time	Rate	Vitals
		left upper arm
		left side pushing
		Ø follow up

Drug completed @ Infusion tolerated well — A/E Ø IV D/C'D with catheter intact NA Patient left walking alone in satisfactory condition, no complaints — Post infusion discharge instructions given — Last Labs: [REDACTED-DATE] Last MD appt: [REDACTED-DATE] Next MD visit: Ø Next Appt: [REDACTED-DATE] @ 10 AM Nurse Emeka Popov Signature [signature] Date [REDACTED-DATE]

STELARA® Order Form

Northview Clinic 3

PATIENT INFORMATION: Name: Zola Nguyen (Patient ID: S-7185261564) Preferred Name: Address: 313 Glenarm Blvd, Nanaimo, ON, Canada J3W 6Q0 Tel: (283) 952-6505 Date of Birth (DD/MM/YYYY): 1996 Gender: Female Allergies: NKDA Indication: Crohn's Disease Secondary Indication: Weight (KG): 48.50 Date of Wt (DD/MM/YYYY): 10/03/2020 Hospital ID:

PRESCRIBING PHYSICIAN INFORMATION: Name: Dr. Pablo Dubois Licence Number: Address: 463 Castlefield Blvd, Nanaimo, ON Y5H 0A2 Tel: (224) 560-8037 Pager: Fax: (865) 998-7318 Ref: RX-1972923576 Pharmacy Name: Stonebridge Health Clinic Fax: (425) 784-7201

PRESCRIBING PHYSICIAN SECTION

Schedule	Starting Week #	Administration	Drug	DIN	Dose	Precision	Frequency	Repeats
Maintenance		Injection	Stelara	02320681	1 x 90 mg Pre-Filled Syringe	Exactly	Every 8 Week(s)	

DURATION: 52 Weeks This is: ☐ first STELARA order for this patient ☒ OR a renewal ☐ OR a change in prescription ☒ Utilize the Stelara I.V. Recommended Standard Protocol to infuse Stelara I.V ☐ Other Infusion Duration:

PRETREATMENT ORDER Option 1 ☒ No pre-medications required Option 2 Please Check desired pretreatment medication(s) administered prior to infusion at clinic (indicate dose/route) ☐ Diphenhydramine (e.g. Benadryl) ____ mg ☐ Acetaminophen ____ mg ☐ Hydrocortisone ____ mg ☐ Dimenhydrinate (e.g. Gravol) ____ mg ☐ Desloratadine ____ mg ☐ Other: ____

RELEVANT MEDICAL/SURGICAL HISTORY, MEDICATION(S) AND NOTES: TB Test ☐ Not required OR Date Completed: 10/04/2019 Result: Negative CXR ☐ Not required OR Date Completed: 08/04/2019 Result: Normal Hep B ☐ Not required OR Date Completed: 08/04/2019 Result: Negative

PRESCRIBER CERTIFICATION I certify that this prescription is an original prescription and will not be reused. Physician Signature: [signature] Date: Mar 10, 2020. *Effective date.

Fax order to: Emeka Popov Fax: (669) 837-3904 672 Main Rd | Alberta, Ontario | Saskatchewan | www.sunnymedfamilypractice.ca © 2014 Highpark Health Centre | All trademarks used under license. All other third party trademarks are the property of their respective owner(s).

Post-injection Feedback Report

(For referring physician's review)

Treatment no. NQ-8075423547

TO:	CONTACT:
Prescribing Physician: Pablo Dubois	Highpark Health Centre Coordinator Name: Emeka Popov
Fax #: (865) 998-7318	Phone #: (726) 651-9832 Fax #: (669) 837-3904

1. PATIENT INFORMATION

Last Name: Nguyen First Name: Zola Date of birth: (DD/MM/YYYY): 1996

2. INJECTION INFORMATION

Medication: Stelara Dose: 90 mg Date of Injection: (DD/MM/YYYY): 26/03/2020 Injection performed at: Physician's Office Was there an adverse event? No

3. NEXT INJECTION

Next Date of Injection: (DD/MM/YYYY): 21/05/2020 Next injection to be performed at: Physician's Office

To be printed and faxed to prescribing physician within 48 hrs

Tremfya™ (guselkumab) Simponi® (golimumab) Stelara® (ustekinumab)

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Glenmore Specialist Centre

Prebiologic Treatment Checklist

clinic or home provider name: Crestwood Medical Group 2 Date: 2020-Mar-25 [?] (DD/MM/YY)

PATIENT-SPECIFIC INFORMATION

1.1 Patient name: Zola Nguyen Patient date of birth: 1996 (DD/MM/YY) Patient weight today: 49.5 kg
Patient sex: ☐ Male ☒ Female

1.2 Vital signs BP: 106/58 Pulse: 80 bpm Resp. rate: 18 Text Temp.: 36.0 Degrees °C

1.3 Allergies: ☐ Yes ☒ No ☐ RPC* If yes, describe or list (e.g., drug, mouse, latex, other?):

1.4 Documented acute reaction†: ☐ Yes ☒ No If yes, please specify: ☐ REMICADE® infusion ☐ STELARA® injection ☐ Entyvio IV ☐ SIMPONI® I.V. infusion ☐ SIMPONI® injection ☐ Inflectra IV ☐ Renflexis

1.5 Last ☐ REMICADE® infusion ☒ STELARA® injection ☐ Inflectra IV ☐ SIMPONI® I.V. infusion ☐ SIMPONI® injection ☐ STELARA Date: [REDACTED-DATE] DD/MM/YYYY ☐ Renflexis ☐ Entyvio IV
Dose: 90 mg

CURRENT DRUG: ☐ REMICADE® ☐ SIMPONI® I.V. ☐ SIMPONI® ☒ STELARA®

1.6 Indication: CD Text ☐ Entyvio IV ☐ Renflexis ☐ Inflectra IV Notes: Text Please refer to the respective product monographs for full indications and safety information.

1.7 Dose to administer today: 90 Text mg/kg or Text mg

1.8 Total to administer: 90 Text mg Checked against REMICADE® / SIMPONI® I.V. infusion or SIMPONI® / STELARA® injection medical order/prescription: Biologic: Text

1.9 Change in current medications (Other than Biologic) ☐ Yes ☒ No

PATIENT PRESCREENING QUESTIONNAIRE

	Yes	No	RPC*	If yes, please explain
1. Since your last REMICADE® / SIMPONI® I.V. infusion or SIMPONI® / STELARA® or other Biologic have you been hospitalized, had surgery, or had to go to the emergency ward?	☐	☒	☐	COVID-19
2. Is there any planned surgery related or not to your disease scheduled in the next 2 months?‡	☐	☒	☐	Ø cough

	Yes	No	RPC*	If yes, please explain
3. Since your last Biologic have you had any vaccinations?	☐	☒	☐	Ø fever
4. Are you planning to receive any vaccinations in the near future?‡	☐	☒	☐	Ø travel
5. Are you currently breastfeeding?	☐	☒	☐	
6. Do you think you are pregnant?	☐	☒	☐	
7. Have you had, or do you currently have, a fever or flu-like symptoms?	☐	☒	☐	
8. Do you currently have any active or recurring infections?	☐	☒	☐	
9. Have you taken any antibiotics since your last Biologic injection, or are you currently taking any antibiotics?	☐	☒	☐	
10. Have you travelled to any TB-endemic areas and/or been exposed to TB since your last Biologic?	☐	☒	☐	

Other comments (patient general/normal appearance): Text

Nurse's signature: [signature] Nurse Initials: JL Date: 26/03/2020 DD-MM-YYYY (DD/MM/YY)

A/E reported to sponsoring company? ☐ Yes ☒ Not applicable

- RPC = record of physician consent; prescribing physician was contacted, and documented consent from prescribing physician was confirmed for treatment indication prescribed. † As documented in the patient's chart at the Cedar Specialist Group 2/home provider. ‡ If patient answers "Yes", this must be documented on the Post-Infusion Feedback Report (REMICADE® and SIMPONI® I.V. patients only).

Glenmore Specialist Centre 2 Nursing Note

DATE: [REDACTED-DATE]

PATIENT NAME: Zola Nguyen

DOB: 1996

Dr. Dubois

T-9084 519289

Crohn's (☒) or Colitis ()

DRUG: Stelara 90mg SQ.

Last infusion date: [REDACTED-DATE]

Shortened ☐

Standard ☐ Q8W

Immunosuppressants:

LABS () yes (☒) no

Allergies: NKDA

TDM () yes ([X]) no

PRE MEDS () yes ([X]) no → →

Drugs: COVID-19

- Ø temp
- Ø travel
- Ø cough

Weight: 49.5kg

Initial Vitals: 106/58 36.[REDACTED-DATE]

Questionnaire: AE () yes () no

IV Insertion @ N/A

Location: () arm

Lot # J1527MB

Expiry date Au 2022

DRUG START @ 1745

Time	Rate	Vitals
		Feels well HBI-Ø

Drug completed @ 1745

Infusion tolerated well

A/E no

IV D/C'D with catheter intact N/A

Patient left walking alone in satisfactory condition, no complaints yes

Post infusion discharge instructions given () yes

Last Labs: [REDACTED-DATE]

Next Appt: [REDACTED-DATE] 9am

Last MD appt: [REDACTED-DATE]

Next MD visit: none booked.

Nurse Emeka Popov **Signature** [signature] **Date** [REDACTED-DATE]

Birchwood Care Clinic

SGC Accredited LAB Accredité CCN TM

Lab ID: 4706-708302 Highpark Health Centre External Ref. No.: 7110691

Prescriber Name: Pablo Dubois **Clinic:** Brookfield Medical Centre 2 **Address:** 871 Harlow Ave Nanaimo, ON Y5H 0A2 **Telephone:** 812.337.5616 **Fax:** 420.616.3265

Patient Name: Nguyen, Zola **Date of birth:** 1996-03-16 **Age:** 24 **Sex:** F **Health Ins.:** 3576963291

Biochemistry

Analysis	Specimen	Result	Reference value	Unit	Status
Calprotectin	Stool	513	<100	µg/g	

Calprotectin Level

(Graph showing three data points: 2019-06-16 at 360, 2019-08-12 at 133, and 2020-04-19 at 513. Horizontal lines at 100 for "Moderate inflammation" and 250 for "Active inflammation")

Collection date	Result (µg/g)
2019-06-16	360
2019-08-12	133
2020-04-19	513

Interpretation: Active inflammation in the gastrointestinal tract. It is recommended to order additional analyses and to optimize the curative treatment under the supervision of medical specialists.

Note: The cut-off level suggested for adults (100 µg/g) can also be used for children aged 4 to 17 years regardless of sex.

Method: Reference values: Normal: < 100 µg/g Moderate inflammation: ≥ 100 - ≤ 250 µg/g Active inflammation: > 250 µg/g

Reference: Bressler B. et al. Clinicians' guide to the use of fecal calprotectin to identify and monitor disease activity in inflammatory bowel disease. Can J Gastroenterol Hepatol. 2015 29(7):369-72.

According to scientific literature, there is a significant bias between different calprotectin analytical methods, reaching differences of up to 5 times*. Due to this variability, it is recommended to always use the same laboratory method for the monitoring of your patient. The method used by Riverside Medical Centre 3 is one of the most used and validated in the scientific literature.

*Reference: Labaere D, Smismans A, Van Olmen A, Christiaens P, D'Haens G, Moons V, Cuyle PJ, Frans J, Bossuyt P. Comparison of six different calprotectin assays for the assessment of inflammatory bowel disease. United European Gastroenterol J. 2014 Feb;2(1):30-7. doi: 10.1177/2050640613518201. PubMed PMID: 24918006; PubMed Central PMCID: PMC4040805.

Comments:

(Signature: Esme Zhang) Esme Zhang, Ph.D, DEPD, CSPQ Clinical Biochemist

Date Collected	Date Received	Partial report	Completed report	Revised report
2020-04-19	2020-04-21	-	2020-04-27	-

514 Cedar St T 653.565.9295 F 465.536.1661

Post-injection Feedback Report

(For referring physician's review)

Treatment no. AQ-2798943403

TO:	CONTACT:
Prescribing Physician: Pablo Dubois	Highpark Health Centre Coordinator Name: Emeka Popov
Fax #: (865) 998-7318	Phone #: (726) 651-9832 Fax #: (669) 837-3904

1. PATIENT INFORMATION

Nguyen	Zola	1996
Last Name	First Name	Date of birth: (DD/MM/YYYY)

2. INJECTION INFORMATION

Medication: Stelara Dose: 90 mg Date of Injection: 21/05/2020 (DD/MM/YYYY) Injection performed at: Westbrook Medical Associates Was there an adverse event? No

3. NEXT INJECTION

Next Date of Injection: 16/07/2020 (DD/MM/YYYY) Next injection to be performed at: Westbrook Medical Associates

To be printed and faxed to prescribing physician within 48 hrs

Tremfya™ (guselkumab) Simponi® golimumab Stelara® ustekinumab

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Highpark Health Centre

Glenmore Specialist Centre Prebiologic Treatment Checklist

clinic or home provider name: Crestwood Medical Group 2 Date: 2020-May-20 [REDACTED-DATE]
(DD/MM/YY)

PATIENT-SPECIFIC INFORMATION 1.1 Patient name: Zola Nguyen Patient date of birth: 1996
(DD/MM/YY) Patient weight today: 53 kg Patient sex: ☐ Male ☒ Female

1.2 Vital signs See Nurses Notes BP: 104/70 Pulse: 72 bpm Resp. rate: 20 Temp.: 37 °C

1.3 Allergies: ☐ Yes ☒ No ☐ RPC* If yes, describe or list (e.g., drug, mouse, latex, other?): NKDA

1.4 Documented acute reaction†: ☐ Yes ☒ No If yes, please specify: ☐ REMICADE® infusion ☐
STELARA® injection ☐ Entyvio IV ☐ SIMPONI® I.V. infusion ☐ SIMPONI® injection ☐ Inflectra IV ☐
Renflexis

1.5 Last ☐ REMICADE® infusion ☒ STELARA® injection ☐ Inflectra IV ☐ SIMPONI® I.V. infusion ☐
SIMPONI® injection ☐ STELARA Date: [REDACTED-DATE] (DD/MM/YYYY) ☐ Renflexis ☐ Entyvio IV
Dose: 90 mg

CURRENT DRUG: ☐ REMICADE® ☐ SIMPONI® I.V. ☐ SIMPONI® ☒ STELARA®

1.6 Indication: Crohn's ☐ Entyvio IV ☐ Renflexis ☐ Inflectra IV Notes: Text Please refer to the respective
product monographs for full indications and safety information.

1.7 Dose to administer today: Stelara Injection 90 mg/kg or 90 mg 1.8 Total to administer: 90 mg Checked
against REMICADE® / SIMPONI® I.V. infusion or SIMPONI® / STELARA® injection medical
order/prescription: Biologic: Stelara

1.9 Change in current medications (Other than Biologic) ☐ Yes ☒ No

PATIENT PRESCREENING QUESTIONNAIRE Covid-19 Screening-any cough, fever, contact, travel or
respiratory symptoms ☐ Yes ☒ No Yes No RPC* If yes, please explain

1. Since your last REMICADE® / SIMPONI® I.V. infusion or SIMPONI® / STELARA® or other Biologic,
have you been hospitalized, had surgery, or had to go to the emergency ward? ☐ ☒ ☐
2. Is there any planned surgery related or not to your disease scheduled in the next 2 months?† ☐ ☒ ☐
☐ COVID (round symbol)
3. Since your last Biologic, have you had any vaccinations? ☐ ☒ ☐
4. Are you planning to receive any vaccinations in the near future?† ☐ ☒ ☐ Ø flare
5. Are you currently breastfeeding? ☐ ☒ ☐ Ø dex
6. Do you think you are pregnant? ☐ ☒ ☐
7. Have you had, or do you currently have, a fever or flu-like symptoms? ☐ ☒ ☐
8. Do you currently have any active or recurring infections? ☐ ☒ ☐
9. Have you taken any antibiotics since your last Biologic injection, or are you currently taking any
antibiotics? ☐ ☒ ☐
10. Have you travelled to any TB-endemic areas and/or been exposed to TB since your last Biologic? ☐
☒ ☐

Other comments (patient general/normal appearance): Text

Nurse's signature: [signature] Text Nurse Initials: [signature] Date: DD-MM-YYYY [REDACTED-DATE] (DD/MM/YY)

AE reported to sponsoring company? [] Yes [X] Not applicable

- RPC = record of physician consent: prescribing physician was contacted, and documented consent from prescribing physician was confirmed for treatment indication prescribed. † As documented in the patient's chart at the Cedar Specialist Group 2/home provider. ‡ If patient answers "Yes", this must be documented on the Post Infusion Feedback Report (REMICADE® and SIMPONI® I.V. patients only).

Glenmore Specialist Centre 2 Nursing Note

DATE: [REDACTED-DATE] PATIENT NAME: Zola Nguyen DOB: 1996 Dr. Dubois T-9084 519289 Crohn's (X) or Colitis () DRUG: Stelara 90mg inj

Shortened Standard

Last infusion date: [REDACTED-DATE] Immunosuppressants:
LABS (X) yes () no TDM (X) yes () no PRE MEDS () yes (X) no → → Drugs: Allergies: NKA
Weight: 53 past Initial Vitals: 37 - 72 - 20 104/70 Questionnaire: AE () yes (X) no
IV Insertion @ [illegible] DRUG START @ [illegible] Location: Lot # JKSI 4 MD Expiry date OCT 2022

Time	Rate	Vitals
		does not feel comfortable
		giving own injection
		gave injection in
		right arm
		and blood was drawn
		for TDM and routine
		blood work

Drug completed @ [blank] Infusion tolerated well ☐ A/E ☐ IV D/C'D with catheter intact [blank] Patient left walking alone in satisfactory condition, no complaints [blank] Post infusion discharge instructions given [blank] Last Labs: [REDACTED-DATE] Last MD appt: [REDACTED-DATE] Next MD visit: [REDACTED-DATE] Next Appt: July 16./06:13 Nurse Conti Signature Conti Date [REDACTED-DATE]

Riverside Medical Centre 3 SGC Accredited LAB LAB Accredited CCN TM Lab ID: Northview Clinic 4
Highpark Health Centre External Ref. No.: 9119852

Prescriber Name: Pablo Dubois Clinic: Brookfield Medical Centre 2 Address: 199 Kestrel Blvd Nanaimo,
ON Y5H 0A2 Telephone: 487.996.2056 Fax: 740.918.5889

Patient Name: Nguyen, Zola Date of birth: 1996-03-16 Age: 24 Sex: F Health Ins.: 3576963291

Note: * Ustekinumab testing procedure (Reflex Testing): Ustekinumab drug levels and antibodies are tested using a stepwise, reflex procedure. Ustekinumab drug levels are tested initially and reported. If the Ustekinumab drug level is below the limit of quantification ($\leq 0.625 \mu\text{g/mL}$) then anti-Ustekinumab antibody levels will be tested and reported.

Biochemistry

Analysis	Specimen	Result	Reference value	Unit	Status
Ustekinumab Drug Level*	Serum	3.350		$\mu\text{g/mL}$	

Interpretation: Therapeutic level

Anti-Ustekinumab antibodies will not be tested

Method: Reference cut-points defined by a consensus of gastroenterologists, applicable in the context of inflammatory bowel diseases:

Subtherapeutic level: $< 1 \mu\text{g/mL}$ Therapeutic level: $1 - 10 \mu\text{g/mL}$ Supratherapeutic level: $> 10 \mu\text{g/mL}$

Therapeutic drug monitoring for Ustekinumab may be used in addition to the patient's clinical evaluation to guide the optimization of treatment.

Comments:

Esme Zhang, Ph.D, DEPD, CSPQ Clinical Biochemist

Date Collected	Date Received	Partial report	Completed report	Revised report
2020-05-21	2020-05-22	-	2020-05-25	-

514 Cedar St T 653.565.9295 F 765.482.3603

STELARA® Order Form

PATIENT INFORMATION:	PRESCRIBING PHYSICIAN INFORMATION:
Name: Zola Nguyen (Patient ID: S-7185261564)	Name: Dr. Pablo Dubois
Preferred Name:	Licence Number:
Address: 313 Glenarm Blvd, Nanaimo, ON, Canada J3W 6Q0	Address: 463 Castlefield Blvd, Nanaimo, ON Y5H 0A2
Tel: (283) 952-6505	Tel: (224) 560-8037
Date of Birth (DD/MM/YYYY): 1996 Gender: Female	Pager:
Allergies: NKDA	Fax: (865) 998-7318
Indication: Crohn's Disease	Ref: DJ-9454695371
Secondary Indication:	
Weight (KG): 53.00 Date of Wt (DD/MM/YYYY): 25/05/2020	Pharmacy Name: Stonebridge Health Clinic
Hospital ID:	Fax: (425) 784-7201

PRESCRIBING PHYSICIAN SECTION

Schedule	Starting Week #	Administration	Drug	DIN	Dose	Precision	Frequency	Repeats
Maintenance		Injection	Stelara	02320681	1 x 90 mg Pre-Filled Syringe	Exactly	Every 4 Week(s)	

DURATION: 52 Weeks This is: ☐ first STELARA order for this patient ☐ OR a renewal ☒ OR a change in prescription ☒ Utilize the Stelara I.V. Recommended Standard Protocol to infuse Stelara I.V. ☐ Other Infusion Duration:

PRETREATMENT ORDER

Option 1 ☒ No pre-medications required **Option 2** Please Check desired pretreatment medication(s) administered prior to infusion at clinic (indicate dose/route) ☐ Diphenhydramine (e.g., Benadryl) _____ mg ☐ Acetaminophen _____ mg ☐ Hydrocortisone _____ mg ☐ Dimenhydrinate (e.g., Gravol) _____ mg ☐ Desloratadine _____ mg ☐ Other: _____

RELEVANT MEDICAL/SURGICAL HISTORY, MEDICATION(S) AND NOTES: TB Test ☐ Not required **OR** Date Completed: 10/04/2019 Result: Negative **CXR** ☐ Not required **OR** Date Completed: 08/04/2019 Result: Normal **Hep B** ☐ Not required **OR** Date Completed: 08/04/2019 Result: Negative

PRESCRIBER CERTIFICATION

I certify that this prescription is an original prescription and will not be reused.

Physician Signature: Pablo Dubois Date: 25/05/2020 *Effective date.*

Fax order to: Emeka Popov Fax: (669) 837-3904 672 Main Rd | Alberta, Ontario | Saskatchewan |
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Post-injection Feedback Report

(For referring physician's review)

Treatment no. NQ-8075423547

TO:	CONTACT:
Prescribing Physician: Pablo Dubois	Highpark Health Centre Coordinator Name: Emeka Popov
Fax #: (865) 998-7318	Phone #: (726) 651-9832 Fax #: (669) 837-3904

1. PATIENT INFORMATION

Nguyen	Zola	1996
Last Name	First Name	Date of birth: (DD/MM/YYYY)

2. INJECTION INFORMATION

Medication: Stelara **Dose:** 90 mg **Date of Injection:** 15/06/2020 (DD/MM/YYYY)

Injection performed at: Westbrook Medical Associates **Was there an adverse event?** No

3. NEXT INJECTION

Next Date of Injection: 16/07/2020 (DD/MM/YYYY) **Next injection to be performed at:** Westbrook Medical Associates

To be printed and faxed to prescribing physician within 48 hrs

Tremfya™ (guselkumab) Simponi® golimumab Stelara® ustekinumab

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INNOVATIVE MEDICINES CANADA

Highpark Health Centre

Glenmore Specialist Centre Prebiologic Treatment Checklist

clinic or home provider name: Crestwood Medical Group 2 Date: 2020-Jun-14 22 Fg (DD/MM/YY)

PATIENT-SPECIFIC INFORMATION

Patient name: Zola Nguyen Patient date of birth: 1996 (DD/MM/YY) Patient weight today: kg 53.3 kg
Patient sex: ☐ Male ☒ Female

1.2 Vital signs

		See Nurses Notes
BP:	tt/tt	116 / 70
Pulse:	bpm	74
Resp. rate:	Text	18
Temp.:	Degrees	36.7 °C

1.3 Allergies: ☐ Yes ☒ No ☐ RPC*

If yes, describe or list (e.g., drug, mouse, latex, other?): NKDA

1.4 Documented acute reaction†: ☐ Yes ☒ No

If yes, please specify: ☐ REMICADE® infusion ☐ STELARA® injection ☐ Entyvio IV ☐ SIMPONI® I.V. infusion ☐ SIMPONI® injection ☐ Inflectra IV ☐ Renflexis

1.5 Last

☐ REMICADE® infusion ☒ STELARA® injection ☐ Inflectra IV ☐ SIMPONI® I.V. infusion ☐ SIMPONI® injection ☐ STELARA Date: [REDACTED-DATE] DD/MM/YYYY ☐ Renflexis ☐ Entyvio IV Dose: mg 90

CURRENT DRUG: ☐ REMICADE® ☐ SIMPONI® I.V. ☐ SIMPONI® ☒ STELARA®

1.6 Indication: Text Crohn's ☐ Entyvio IV ☐ Renflexis ☐ Inflectra IV

Notes: Text

Please refer to the respective product monographs for full indications and safety information.

1.7 Dose to administer today:

Stelara 90 mg/kg or 90 mg

1.8 Total to administer: 90 mg

Checked against REMICADE® / SIMPONI® I.V. infusion or SIMPONI® / STELARA® injection medical order/prescription: Biologic: Text y

1.9 Change in current medications (Other than Biologic)

☐ Yes ☒ No

PATIENT PRESCREENING QUESTIONNAIRE

Covid-19 Screening-any cough, fever, contact, travel or respiratory symptoms ☐ Yes ☒ No

	Yes	No	RPC*	If yes, please explain
1. Since your last REMICADE® / SIMPONI® I.V. infusion or SIMPONI® / STELARA® or other Biologic, have you been hospitalized, had surgery, or had to go to the emergency ward?	☐	☒	☐	
2. Is there any planned surgery related or not to your disease scheduled in the next 2 months?‡	☐	☒	☐	
3. Since your last Biologic, have you had any vaccinations?	☐	☒	☐	0 flare up
4. Are you planning to receive any vaccinations in the near future?‡	☐	☒	☐	0 new meds
5. Are you currently breastfeeding?	☐	☒	☐	
6. Do you think you are pregnant?	☐	☒	☐	thinks pass
7. Have you had, or do you currently have, a fever or flu-like symptoms?	☐	☒	☐	↑ slightly in
8. Do you currently have any active or recurring infections?	☐	☒	☐	frequency
9. Have you taken any antibiotics since your last Biologic injection, or are you currently taking any antibiotics?	☐	☒	☐	of stool
10. Have you travelled to any TB-endemic areas and/or been exposed to TB since your last Biologic?	☐	☒	☐	

Other comments (patient general/normal appearance): Text

Nurse's signature: [signature] Nurse Initials: JL Date: 15/06/2020 RL (DD/MM/YY)

A/E reported to sponsoring company? ☐ Yes ☒ Not applicable

*RPC = record of physician consent; prescribing physician was contacted, and documented consent from prescribing physician was confirmed for treatment indication prescribed. † Documented in the patient's chart at the Cedar Specialist Group 2/home provider. ‡ If patient answers "Yes", this must be documented on the Post-Infusion Feedback Report (REMICADE® and SIMPONI® I.V. patients only).

Glenmore Specialist Centre 2 Nursing Note DATE: 15/06/2020

PATIENT NAME: Nguyen, Zola DOB: 1996 Dr. Dubois S-7185261564 Crohn's (✓) or Colitis () DRUG: Stelara 90 mg injection Last infusion date: 21/05/2020 Shortened [X] Standard Q4W Immunosuppressants:

LABS () yes (✓) no Allergies: NKDA TDM () yes (✓) no PRE MEDS () yes (✓) no → → Drugs:

last -- ? 53 kg Weight: 53.3 Initial Vitals: 36.7 74-18 116/70 Questionnaire: AE () yes () no

IV Insertion @ N/A Location: Lot # TYA8LNE DRUG START @ N/A Expiry date [REDACTED-DATE].

Time	Rate	Vitals

Drug completed @ N/A Infusion tolerated well — A/E — IV D/C'D with catheter intact — Patient left walking alone in satisfactory condition, no complaints — Post infusion discharge instructions given — Last Labs: 21/05/2020 Next Appt: Jul 16, 2020 Last MD appt: 07/04/2020 @ 10:15 Next MD visit: 09/11/2020 Nurse Emeka Popov Signature: [signature] Date 15/06/2020

Post-injection Feedback Report

(For referring physician's review)

Treatment no. LQ-9861394546

TO:	CONTACT:
Prescribing Physician: Pablo Dubois	Highpark Health Centre Coordinator Name: Emeka Popov
Fax #: (865) 998-7318	Phone #: (726) 651-9832 Fax #: (669) 837-3904

1. PATIENT INFORMATION

Nguyen	Zola	1996
Last Name	First Name	Date of birth: (DD/MM/YYYY)

2. INJECTION INFORMATION

Medication: Stelara **Dose:** 90 mg **Date of Injection:** 16/07/2020 (DD/MM/YYYY)

Injection performed at: Westbrook Medical Associates **Was there an adverse event?** No

3. NEXT INJECTION

Next Date of Injection: 13/08/2020 (DD/MM/YYYY) **Next injection to be performed at:** Westbrook Medical Associates

To be printed and faxed to prescribing physician within 48 hrs

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Highpark Health Centre

Glenmore Specialist Centre Prebiologic Treatment Checklist

clinic or home provider name: Crestwood Medical Group 2 Date: 2020-Jul-15 17 RJ (DD/MM/YY)

PATIENT-SPECIFIC INFORMATION

1.1 Patient name: Zola Nguyen Patient date of birth: 1996 (DD/MM/YY) Patient weight today: 53.7 kg kg
Patient sex: ☐ Male ☒ Female

1.2 Vital signs BP: tt/tt (blank) Pulse: (blank) bpm See Nurses Notes Resp. rate: Text (blank) Temp.: Degrees (blank) °C

1.3 Allergies: ☐ Yes ☒ No ☐ RPC* If yes, describe or list (e.g., drug, mouse, latex, other?): (blank)

1.4 Documented acute reaction† : ☐ Yes ☒ No If yes, please specify: ☐ REMICADE® infusion ☐ STELARA® injection ☐ Entyvio IV ☐ SIMPONI® I.V. infusion ☐ SIMPONI® injection ☐ Inflectra IV ☐ Renflexis

1.5 Last ☐ REMICADE® infusion ☒ STELARA® injection ☐ Inflectra IV ☐ SIMPONI® I.V. infusion ☐ SIMPONI® injection ☐ STELARA Date: 90 DD/MM/YYYY 15/06/2020 ☐ Renflexis ☐ Entyvio IV Dose: mg (blank) CURRENT DRUG: ☐ REMICADE® ☐ SIMPONI® I.V. ☐ SIMPONI® ☒ STELARA®

1.6 Indication: Text CD ☐ Entyvio IV ☐ Renflexis ☐ Inflectra IV Notes: Text Q4W Please refer to the respective product monographs for full indications and safety information.

1.7 Dose to administer today: Text mg/kg or 90 Text mg

1.8 Total to administer: 90 Text mg Checked against REMICADE® / SIMPONI® I.V. infusion or SIMPONI® / STELARA® injection medical order/prescription: Biologic: Text Y

1.9 Change in current medications (Other than Biologic) ☐ Yes ☒ No

PATIENT PRESCREENING QUESTIONNAIRE

Covid-19 Screening-any cough, fever, contact, travel or respiratory symptoms ☐ Yes ☒ No

	Yes	No	RPC*	If yes, please explain
1. Since your last REMICADE® / SIMPONI® I.V. infusion or SIMPONI® / STELARA® or other Biologic have you been hospitalized, had surgery, or had to go to the emergency ward?	☐	☒	☐	
2. Is there any planned surgery related or not to your disease scheduled in the next 2 months?‡	☐	☒	☐	Covid Screening ☺
3. Since your last Biologic have you had any vaccinations?	☐	☒	☐	Ø Flare ups

	Yes	No	RPC*	If yes, please explain
4. Are you planning to receive any vaccinations in the near future?†	☐	☒	☐	
5. Are you currently breastfeeding?	☐	☒	☐	
6. Do you think you are pregnant?	☐	☒	☐	
7. Have you had, or do you currently have, a fever or flu-like symptoms?	☐	☒	☐	
8. Do you currently have any active or recurring infections?	☐	☒	☐	
9. Have you taken any antibiotics since your last Biologic injection, or are you currently taking any antibiotics?	☐	☒	☐	
10. Have you travelled to any TB-endemic areas and/or been exposed to TB since your last Biologic ?	☐	☒	☐	

Other comments (patient general/normal appearance): Text (blank) Text (blank)

Nurse's signature: Liam Takahashi Nurse Initials: RJ Date: DD-MM-YYYY 16/07/2020 (DD/MM/YY)

A/E reported to sponsoring company? ☐ Yes ☒ Not applicable

- RPC = record of physician consent; prescribing physician was contacted, and documented consent from prescribing physician was confirmed for treatment indication prescribed. † As documented in the patient's chart at the Cedar Specialist Group 2/home provider. ‡ If patient answers "Yes", this must be documented on the Post-Infusion Feedback Report (REMICADE® and SIMPONI® I.V. patients only).

Cedar Specialist Group 3 Nursing Note DATE: 16/07/2020

PATIENT NAME: Nguyen, Zola DOB: 1996 Dr. Dubois L-5786 8 97863 Crohn's (☐) or Colitis (☐) Last infusion date: 15/06/2020 DRUG: Stelara 90 mg injection Shortened Q4W Immunosuppressants: Standard

LABS (☐) yes (☐) no Allergies: NKDA TDM (☐) yes (☐) no PRE MEDS (☐) yes (☐) no → → Drugs:

last 53.3 kg Weight: 53.7 kg Initial Vitals: 36.9 111/83 80 16 Questionnaire: AE (☐) yes (☐) no

IV Insertion @ N/A Location: Lot # KB530MA Expiry date [REDACTED-DATE] DRUG START @ 1014

Time	Rate	Vitals
1014		Stelara 90 mg injection
		administered

Drug completed @ 1015 Infusion tolerated well ☐ A/E IV D/C'D with catheter intact Patient left walking alone in satisfactory condition, no complaints ☐ Post infusion discharge instructions given Last Labs:

21/05/2020 Next Appt: 13/08/2020 Last MD appt: 25/05/2020 Next MD visit: 09/11/2020 Nurse Liam
Takahashi Signature Liam Takahashi Date 16/07/2020

Post-injection Feedback Report

(For referring physician's review)

Treatment no. LQ-9861394546

TO:	CONTACT:
Prescribing Physician: Pablo Dubois	Highpark Health Centre Coordinator Name: Emeka Popov
Fax #: (865) 998-7318	Phone #: (726) 651-9832 Fax #: (669) 837-3904

1. PATIENT INFORMATION

Nguyen	Zola	1996
Last Name	First Name	Date of birth: (DD/MM/YYYY)

2. INJECTION INFORMATION

Medication: Stelara Dose: 90 mg Date of Injection: 13/08/2020 (DD/MM/YYYY)

Injection performed at: Westbrook Medical Associates Was there an adverse event? No

3. NEXT INJECTION

Next Date of Injection: 10/09/2020 (DD/MM/YYYY) Next injection to be performed at: Westbrook Medical Associates

To be printed and faxed to prescribing physician within 48 hrs

Tremfya™ (guselkumab) Simponi® golimumab Stelara® ustekinumab

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Highpark Health Centre

Highpark Health Centre 2

Post-injection Feedback Report (For referring physician's review)

Treatment no. MW-1558968577

TO:	CONTACT:
Prescribing Physician: Pablo Dubois	Highpark Health Centre Coordinator Name: Emeka Popov
Fax #: (865) 998-7318	Phone #: (726) 651-9832 Fax #: (669) 837-3904

1. PATIENT INFORMATION

Zola Nguyen 1996 Last Name First Name Date of birth: (DD/MM/YYYY)

2. INJECTION INFORMATION

Medication: Stelara Dose: 90 mg Date of Injection: 10/09/2020 (DD/MM/YYYY) Injection performed at: Westbrook Medical Associates Was there an adverse event? No

3. NEXT INJECTION

Next Date of Injection: 08/10/2020 (DD/MM/YYYY) Next injection to be performed at: Westbrook Medical Associates

To be printed and faxed to prescribing physician within 48 hrs

Tremfya (guselkumab) Simponi golimumab Stelara ustekinumab

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Post-injection Feedback Report

(For referring physician's review)

Treatment no. NQ-8075423547

TO:	CONTACT:
Prescribing Physician: Pablo Dubois	Highpark Health Centre Coordinator Name: Emeka Popov
Fax #: (865) 998-7318	Phone #: (726) 651-9832 Fax #: (669) 837-3904

1. PATIENT INFORMATION

Last Name: Nguyen First Name: Zola Date of birth: (DD/MM/YYYY): 1996

2. INJECTION INFORMATION

Medication: Stelara Dose: 90 mg Date of Injection: 08/10/2020 (DD/MM/YYYY) Injection performed at: Westbrook Medical Associates Was there an adverse event? No

3. NEXT INJECTION

Next Date of Injection: 05/11/2020 (DD/MM/YYYY) Next injection to be performed at: Westbrook Medical Associates

To be printed and faxed to prescribing physician within 48 hrs

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Page 1 of 1 Patient: Zola Nguyen PHN: 4971549172-ER DOB: 1996

Post-injection Feedback Report

(For referring physician's review)

Treatment no. GD-1457868978

TO:	CONTACT:
Prescribing Physician: Pablo Dubois	Highpark Health Centre Coordinator Name: Emeka Popov
Fax #: (865) 998-7318	Phone #: (697) 738-3445 Fax #: (669) 837-3904

1. PATIENT INFORMATION

Nguyen / Zola / 1996 Last Name / First Name / Date of birth: (DD/MM/YYYY)

2. INJECTION INFORMATION

Medication: Stelara Dose: 90 mg Date of Injection: 05/11/2020 (DD/MM/YYYY)

Injection performed at: Westbrook Medical Associates Was there an adverse event? No

3. NEXT INJECTION

Next Date of Injection: 03/12/2020 (DD/MM/YYYY) Next injection to be performed at: Westbrook Medical Associates

To be printed and faxed to prescribing physician within 48 hrs

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Page 1 of 1 Patient: Zola Nguyen PHN: 8186259942QA DOB: 1996

Birchwood Care Clinic

SGC Accredited LAB LAB Accredité CCN

Lab ID: 7863-084497 Stonebridge Health Clinic 3 External Ref. No.: 1966736

Prescriber Name: Pablo Dubois **Clinic:** Brookfield Medical Centre 2 **Address:** 285 Victoria St112 Aldergrove Ave **Telephone:** 487.996.2056 **Fax:** 740.918.5889

Patient Name: Nguyen, Zola **Date of birth:** 1996-03-16 **Age:** 24 **Sex:** F **Health Ins.:** 3576963291

Biochemistry

Analysis	Specimen	Result	Reference value	Unit	Status
Calprotectin	Stool	674	<100	µg/g	

Calprotectin Level

Collection date	Result (µg/g)
2019-06-16	360
2019-08-12	133
2020-04-19	513
2020-11-22	674

(Graph depicting Calprotectin Level over time: [REDACTED-DATE]: 360, [REDACTED-DATE]: 133, [REDACTED-DATE]: 513, [REDACTED-DATE]: 674. Y-axis µg/g 0-600. Threshold lines at 100 for "Moderate inflammation" and 250 for "Active inflammation".)

Interpretation: Active inflammation in the gastrointestinal tract. It is recommended to order additional analyses and to optimize the curative treatment under the supervision of medical specialists. **Note:** The cut-off level suggested for adults (100 µg/g) can also be used for children aged 4 to 17 years regardless of sex. **Method:**

Reference values: Normal: < 100 µg/g Moderate inflammation: ≥ 100 - ≤ 250 µg/g Active inflammation: > 250 µg/g

Reference: Bressler B. et al. Clinicians' guide to the use of fecal calprotectin to identify and monitor disease activity in inflammatory bowel disease. Can J Gastroenterol Hepatol. 2015 29(7):369-72.

According to scientific literature, there is a significant bias between different calprotectin analytical methods, reaching differences of up to 5 times*. Due to this variability, it is recommended to always use the same laboratory method for the monitoring of your patient. The method used by Riverside Medical Centre 3 is one of the most used and validated in the scientific literature.

*Reference: Labaere D, Smismans A, Van Olmen A, Christiaens P, D'Haens G, Moons V, Cuyle PJ, Frans J, Bossuyt P. Comparison of six different calprotectin assays for the assessment of inflammatory bowel

disease. United European Gastroenterol J. 2014 Feb;2(1):30-7. doi: 10.1177/2050640613518201. PubMed PMID: 24918006; PubMed Central PMCID: PMC4040805.

Comments:

!signature Esme Zhang, Ph.D, DEPD, CSPQ Clinical Biochemist

Date Collected	Date Received	Partial report	Completed report	Revised report
2020-11-22	2020-11-23	-	2020-11-26	-

514 Cedar St T 653.565.9295 F 765.482.3603

Highpark Health Centre 2

Post-injection Feedback Report (For referring physician's review)

Treatment no. NQ-8075423547

TO:	CONTACT:
Prescribing Physician: Pablo Dubois	Highpark Health Centre Coordinator Name: Emeka Popov
Fax #: (865) 998-7318	Phone #: (232) 311-6562 Fax #: (669) 837-3904

1. PATIENT INFORMATION

Nguyen / Zola / 1996 Last Name / First Name / Date of birth: (DD/MM/YYYY)

2. INJECTION INFORMATION

Medication: Stelara Dose: 90 mg Date of Injection: 03/12/2020 (DD/MM/YYYY) Injection performed at: Westbrook Medical Associates Was there an adverse event? No

3. NEXT INJECTION

Next Date of Injection: 03/01/2021 (DD/MM/YYYY) Next injection to be performed at: Westbrook Medical Associates

To be printed and faxed to prescribing physician within 48 hrs

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Stonebridge Health Clinic 3

Patient: Zola Nguyen PHN: 8186259942QA DOB: 1996

Brookfield Medical Centre Brookfield Medical Centre 556 Fennimore Ave Nanaimo Ontario T8X 0V9

Administration Outpatient Services 2nd Floor

Tel: (496) 839-2065 Fax: (621) 857-7494

MRI Appointment Notification

Dr.: Pablo Dubois

Patient Name: Zola Nguyen

Booking Date & Time: [REDACTED-DATE] @ 6234

Please contact your patient with date and time of appointment **immediately** to minimize patient inquiries.

PLEASE NOTE CHANGE TO INSTRUCTIONS

For all **MRI - ENTEROGRAPHY** appointments:

- patient must remain **NPO for 3 hours** prior to appointment.
- patient to bring in 2L of either apple or cranberry juice according to his/her preference. Juice may be chilled.
- patient must **arrive 2 hours early** for oral contrast preparation.

If your patient is claustrophobic, the physician is responsible for providing the patient with sedation and making the patient aware that they must bring a driver with them.

Your patient will receive a phone confirmation within 3-5 days prior to their scheduled appointment.

*www.riversidemedicalcentre.ca

Fax Number: 663-964-2399 Recipient: XXUUCD3980

Riverside Medical Centre 4 Administration - Outpatient Services, Main Lobby (Level 2) Tel: (496) 839-2065
MRI Appointment Notification

****As of June 2016, MRI EXAMINATIONS WILL BE BOOKED 24 HOURS/DAY**** Please ensure patients are aware appointments can be booked during midnight hours. The appointment times below are stated in military time (using the 24 hour clock). Please ensure all patients clearly understand whether their appointment is booked in the AM or PM

Pablo Dubois Fax 663-964-2399 (Nanaimo)

The following patients have had appointments booked in Community-Wide Scheduling between 15/12/2020 and 16/12/2020

Patient	HCN	Scheduled For	Appointment Type
Nguyen, Zola	4971549172-ER	[REDACTED-DATE] @ 6234	MRI ENTEROGRAPHY

ALL PATIENTS MUST ARRIVE 45 MINUTES PRIOR TO APPOINTMENT FOR REGISTRATION, SAFETY SCREENING AND PREPARATION.

Contact your patient with date and time of appointment IMMEDIATELY to minimize patient inquiries and No Shows

For environmental reasons, General Medicine has stopped issuing plastic bags. We ask that you request patients bring their own reusable bag to hold their garments during their exam.

If your patient is claustrophobic, the physician is responsible for providing the patient with sedation and making the patient aware that they must bring a driver with them. We advise that the patient takes sedation prior to arrival to ensure the patient is sedated for appointment.

Your patient will receive a phone confirmation approximately 1 week prior to their scheduled appointment.

****END OF REPORT****

Highpark Health Centre 2

Post-injection Feedback Report (For referring physician's review)

Treatment no. NQ-8075423547

TO:	CONTACT:
Prescribing Physician: Pablo Dubois	Highpark Health Centre Coordinator Name: Emeka Popov
Fax #: 663-964-2399	Phone #: (232) 311-6562 Fax #: (669) 837-3904

1. PATIENT INFORMATION

Last Name: Nguyen First Name: Zola Date of birth: (DD/MM/YYYY) 1996

2. INJECTION INFORMATION

Medication: Stelara Dose: 90 mg Date of Injection: 03/01/2021 (DD/MM/YYYY) Injection performed at: Westbrook Medical Associates Was there an adverse event? No

3. NEXT INJECTION

Next Date of Injection: 28/01/2021 (DD/MM/YYYY) Next injection to be performed at: Westbrook Medical Associates

To be printed and faxed to prescribing physician within 48 hrs

Tremfya (guselkumab) *Simponi* golimumab *Stelara* ustekinumab

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Page 1 of 1 Patient: Zola Nguyen PHN: 4971549172-ER DOB: 1996

![[Ridgeway Family Health 2 logo]]

Post-injection Feedback Report

(For referring physician's review)

Treatment no. UU-0139806234

TO:	CONTACT:
Prescribing Physician: Pablo Dubois	Highpark Health Centre Coordinator Name: Cubtf Lxnyym
Fax #: 663-964-2399	Phone #: (232) 311-6562 Fax #: (669) 837-3904

1. PATIENT INFORMATION

Nguyen	Zola	1996
Last Name	First Name	Date of birth: (DD/MM/YYYY)

2. INJECTION INFORMATION

Medication: Stelara **Dose:** 90 mg **Date of Injection:** 28/01/2021 (DD/MM/YYYY) **Injection performed at:** Westbrook Medical Associates **Was there an adverse event?** No

3. NEXT INJECTION

Next Date of Injection: 25/02/2021 (DD/MM/YYYY) **Next injection to be performed at:** Westbrook Medical Associates

To be printed and faxed to prescribing physician within 48 hrs

![[Tremfya logo]] ![[Simponi logo]] ![[Stelara logo]]

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![[Stonebridge Health Clinic 3 logo]]

Stonebridge Health Clinic 3 **Brookfield Medical Centre 5**

Post-injection Feedback Report (For referring physician's review)

Treatment no. AQ-2798943403

TO:	CONTACT:
Prescribing Physician: Pablo Dubois	Highpark Health Centre Coordinator Name: Cubtf Lxnyym
Fax #: 663-964-2399	Phone #: (232) 311-6562 Fax #: (669) 837-3904

1. PATIENT INFORMATION

Nguyen	Zola	1996
Last Name	First Name	Date of birth: (DD/MM/YYYY)

2. INJECTION INFORMATION

Medication: Stelara	Dose: 90 mg	Date of Injection: 25/02/2021
		(DD/MM/YYYY)

Injection performed at: Westbrook Medical Associates	Was there an adverse event? No
--	--------------------------------

3. NEXT INJECTION

Next Date of Injection: 25/03/2021	Next injection to be performed at: Westbrook Medical Associates
(DD/MM/YYYY)	

To be printed and faxed to prescribing physician within 48 hrs

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|

Post-injection Feedback Report

(For referring physician's review)

Treatment no. GP-6708754042

TO: (blank)

CONTACT: (blank)

Prescribing Physician: Pablo Dubois Fax #: 663-964-2399

Highpark Health Centre Coordinator Name: Cubtf Lxnyym Phone #: 623-478-4875 Fax #: (669) 837-3904

1. PATIENT INFORMATION

Last Name: Nguyen First Name: Zola Date of birth: (DD/MM/YYYY): 1996

2. INJECTION INFORMATION

Medication: Stelara Dose: 90 mg Date of Injection: 25/03/2021 (DD/MM/YYYY) Injection performed at: Birchwood Care Clinic 3 Was there an adverse event? No

3. NEXT INJECTION

Next Date of Injection: 22/04/2021 (DD/MM/YYYY) Next injection to be performed at: Birchwood Care Clinic 3

To be printed and faxed to prescribing physician within 48 hrs

Tremfya® (guselkumab) Simponi® golimumab Stelara® (ustekinumab)

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Stonebridge Health Clinic 3

Patient: Zola Nguyen PHN: 8186259942QA DOB: 1996

REMICADE® I.V. (DIN: 02244016) Order Form Crestwood Medical Group

PATIENT INFORMATION: Name: Zola Nguyen (Patient ID: S-7185261564) Preferred Name: Address: 499 Pine St, Nanaimo, ON, Canada V0H 6P1 Tel: (283) 952-6505 Date of Birth (DD/MM/YYYY): 1996 Gender: Female Allergies: NKDA Indication: Crohn's Disease Secondary Indication: Weight (KG): 52.00 Date of Wt (DD/MM/YYYY): 30/03/2021 Hospital ID:

PRESCRIBING PHYSICIAN INFORMATION: Name: Dr. Pablo Dubois Licence Number: Address: 308 Harlow Ave, Nanaimo, ON Y5H 0A2 Tel: (925) 984-3967 Pager: Fax: 663-964-2399 Ref: TN-5961887701 Pharmacy Name: Stonebridge Health Clinic Fax: (495) 811-7160

PRESCRIBING PHYSICIAN SECTION

Schedule	Starting Week #	Administration	Drug	DIN	Dose	Precision	Frequency	Repeats
Induction	0	Infusion	Remicade	02244016	300 mg	Exactly		
Induction	2	Infusion	Remicade	02244016	300 mg	Exactly		
Induction	6	Infusion	Remicade	02244016	300 mg	Exactly		
Maintenance	14	Infusion	Remicade	02244016	300 mg	Exactly	Every 8 Week(s)	

DURATION: 52 Weeks

No substitutions

This is: ☒ first REMICADE order for this patient ☐ OR a renewal ☐ OR a change in prescription

☒ Utilize the Recommended Standard Protocol to infuse REMICADE over no less than 2 hours or as tolerated, and manage infusion reactions as applicable. (Patients eligible for shortened infusion have been diagnosed with active Rheumatoid Arthritis)

☐ If my patient has received the last three 2-hour infusions without any type of infusion reaction, initiate following order: Utilize the Shortened Infusion Recommended Standard Protocol to infuse REMICADE over no less than 1 hour, or as tolerated, and manage infusion reactions as applicable. (Patients eligible for shortened infusion have been diagnosed with active Rheumatoid Arthritis)

☐ Other:

PRETREATMENT ORDER Option 1 ☒ No pre-medications required Option 2 ☐ Please Check desired pretreatment medication(s) administered prior to infusion at clinic (indicate dose/route) ☐ Diphenhydramine (e.g., Benadryl) _____ mg _____ ☐ Acetaminophen _____ mg

_____ ☐ Hydrocortisone _____ mg

_____ ☐ Dimenhydrinate (e.g., Gravol) _____ mg

_____ ☐ Desloratadine _____ mg

_____ ☐ Other:

RELEVANT MEDICAL/SURGICAL HISTORY, MEDICATION(S) AND NOTES: TB Test ☐ Not required OR
Date Completed: 10/04/2019 Result:Negative CXR ☐ Not required OR Date Completed: 08/04/2019
Result:Normal Hep B ☐ Not required OR Date Completed: 08/04/2019 Result:Negative

PRESCRIBER CERTIFICATION I certify that this prescription is an original prescription and will not be reused.
Physician Signature: [signature: Pablo Dubois] Date: Mar 31, 2021 *Effective date:

Fax order to: Cubtf Lxnyym Fax: (669) 837-3904 Alberta | New Brunswick, Ontario | F1Z 0G6 |
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Lab ID: Ridgeway Family Health 3 Stonebridge Health Clinic 3 External Ref. No.: 4997738

Prescriber		Patient	
Name:	Pablo Dubois	Name:	Nguyen, Zola
Clinic:	Brookfield Medical Centre 2		
Address:	308 Harlow Ave Nanaimo, ON Y5H 0A2	Date of birth:	1996-03-16 Age: 25
Telephone:	487.996.2056	Sex:	F
Fax:	740.918.5889	Health Ins.:	3576963291

Biochemistry

Analysis	Specimen	Result	Reference value	Unit	Status
Calprotectin	Stool	272	<100	µg/g	

Calprotectin Level

[image: A line graph showing calprotectin levels over time. Data points are plotted for [REDACTED-DATE] (~360), [REDACTED-DATE] (~133), [REDACTED-DATE] (~513), [REDACTED-DATE] (~674), and [REDACTED-DATE] (~272). Horizontal dashed lines indicate "Moderate inflammation" at 100 and "Active inflammation" at 250.]

Collection date	Result (µg/g)
2019-06-16	360
2019-08-12	133
2020-04-19	513
2020-11-22	674
2021-04-07	272

Interpretation: Active inflammation in the gastrointestinal tract. It is recommended to order additional analyses and to optimize the curative treatment under the supervision of medical specialists.

Note: The cut-off level suggested for adults (100 µg/g) can also be used for children aged 4 to 17 years regardless of sex.

Method: Reference values:

Normal: < 100 µg/g Moderate inflammation: ≥ 100 - ≤ 250 µg/g Active inflammation: > 250 µg/g

Reference: Bressler B. et al. Clinicians' guide to the use of fecal calprotectin to identify and monitor disease activity in inflammatory bowel disease. Can J Gastroenterol Hepatol. 2015 29(7):369-72.

Fecal calprotectin quantification is performed with the Buhlmann fCAL Turbo immunoturbidimetric assay and the Roche COBAS c311 analyzer, replacing the Buhlmann fCAL ELISA assay used until March 2021. Both methods use the same antibody for the capture of calprotectin and in-house correlation studies did not show significant deviation between the methods.

The immunoturbidimetric method has a negative bias compared to the ELISA method. Below 1,500 µg/g, calprotectin values determined by the new method are approximately 15% lower than values determined by ELISA. Above 1,500 µg/g, this bias can reach up to 40%. There is no change to the interpretation of the results and the literature-based clinical cutoff intervals remain the same.

!signature Esme Zhang, Ph.D, DEPD, CSPQ Clinical Biochemist

Date Collected	Date Received	Partial report	Completed report	Revised report
2021-04-07	2021-04-08	-	2021-04-15	-

514 Cedar St T 653.565.9295 F 765.482.3603

Complaint
Vendor Number
Is this a possible Adverse Event or Special Situation? Yes
Is this a possible Product Quality Complaint? No
Was this complaint reported from a J&J program? No
When was J&J first notified of this complaint? Apr 21, 2021
Provide the narrative or additional information here Started LD # 1 of Remicade today BP at start 101/69 started at second increase C/O lip tingling she is notably anxious and has anxiety history called to Dr Dubois infusion rate slowed and given benedryl 25 mg IV Bp 88/59 then increased IV fluid 500 cc infused total and BP Increased to 102/69 she has no more tingling in lip and infusion continued per MD

Reporter Details
Details about the person who informed you of this complaint 1
Select the person who informed you of this complaint Patient
Has the Patient provided permission to contact the physician or treating HCP? Not asked
Is the physician or treating HCP aware of the complaint? Not asked
Title Mrs.
First Name Emeka
Last Name Popov
Facility Name Glenmore Specialist Centre 6
Address Line 1 134 Brookmere Blvd Nanaimo ON G3V 7D2
Address Line 2
City Nanaimo
County
State ON
Postal Code G3V 7D2
Country CANADA
Telephone 487.996.2056
Fax 740.918.5889
Email Address
Did the reporter administer the product? Yes
Does J&J have permission to contact the reporter? Yes

Reporter Details
Did the reporter send this report to the FDA?

Products
Provide details if concomitant medication was used
Products 1(Primary Suspect Product)
J&J Product Name REMICADE [Drug] [Solution for infusion]

Patient: Zola Nguyen PHN: 4971549172-ER DOB: 1995 Date of Report [REDACTED-DATE]

Ref ID: CDT05426574665(S7) Submitted by: vivienne.lambert35@cedarspecialistgroup.ca

Product purchased in	CANADA
Vaccine Anatomical Approach Site	
Was the product stored in appropriate temperature conditions? and was it properly stored from receipt to administration? If not, please explain (ex: delay in cold storage, temperature excursions, etc.)	
Please Explain	
If a multidose vial, how many times, and for how long (cumulative), was the vaccine removed from storage?	
What was the formulation?	Solution for infusion
Indication	Crohns Disease
What was the route of administration?	Intravenous drip
What action was taken in response to the complaint?	
Start	
End	
Is the product lot number available?	Yes
Provide the lot number of the product	FGF27908
Provide the product expiration date	01-Nov-2023
Is the product sample available?	No
Provide the reason why sample is not available	Discarded
Specify Other	
Number of units involved in this Complaint	3
What was the dose?	300 (Mg milligram(s))

What was the strength?	100 (Mg milligram(s))
What was the frequency?	1
What was the frequency time?	8 (Week)
Where was the product purchased?	
Contact Phone Number for where product was purchased	
Place where product was administered	Clinic
Who administered the product?	Other Health Professional
Provide the controlled substance number (for controlled substances only)	
Provide the GTIN number	
Provide the NDC number	
Provide the UDI number	
Provide the Serial number	
EEA system alert number	
EEA system alert description	
Provide the Prescription number	

Patient: Zola Nguyen PHN: 8186259942QA DOB: 1996 Date of Report [REDACTED-DATE] Page 2 of 6

Ref ID : CDT05426574665(S7) Submitted by : vivienne.lambert35@cedarspecialistgroup.ca

Is the complaint related to a specific part used to administer the product?	
Describe which specific part of the device or device component was involved	
When did the problem occur?	
Did the patient experience harm from the product problem?	
Describe the harm the patient experienced from the product problem	
Were the product instructions for use followed?	
Describe why the instructions were not followed	
Who was using the device(operator of the device)	
Was single use device reprocessed and reused?	

Usage of device	
Complaint Description	LOW BP AND TINGLING IN UPPER LIP AFTER INFUSION STARTED
According to the reporter, is this complaint related to J&J product?	Unknown
Did the complaint abate after user stopped or the dose reduced?	
Did the complaint reappear after reintroduction?	

Products 2(Other Suspect Product(s))	
J&J Product Name	REMICADE [Drug] [Solution for infusion]
Product purchased in	CANADA
Vaccine Anatomical Approach Site	
Was the product stored in appropriate temperature conditions? and was it properly stored from receipt to administration? If not, please explain (ex: delay in cold storage, temperature excursions, etc .)	
Please Explain	
If a multidose vial, how many times, and for how long (cumulative), was the vaccine removed from storage?	
What was the formulation?	Solution for infusion
Indication	
What was the route of administration?	
What action was taken in response to the complaint?	
Start	
End	
Is the product lot number available?	Yes
Provide the lot number of the product	FGF27908
Provide the product expiration date	01-Nov-2023

Patient: Zola Nguyen PHN: 4971549172-ER DOB: 1995 Date of Report [REDACTED-DATE]

Ref ID : CDT05426574665(S7) Submitted by : vivienne.lambert35@cedarspecialistgroup.ca

Is the product sample available?	No
Provide the reason why sample is not available	Other

Specify Other	dose administered
Number of units involved in this Complaint	3
What was the dose?	300 (Mg milligram(s))
What was the strength?	100 (Mg milligram(s))
What was the frequency?	1
What was the frequency time?	8 (Week)
Where was the product purchased?	Pharmacy
Contact Phone Number for where product was purchased	
Place where product was administered	
Who administered the product?	
Provide the controlled substance number (for controlled substances only)	
Provide the GTIN number	
Provide the NDC number	
Provide the UDI number	
Provide the Serial number	
EEA system alert number	
EEA system alert description	
Provide the Prescription number	
Is the complaint related to a specific part used to administer the product?	
Describe which specific part of the device or device component was involved	
When did the problem occur?	
Did the patient experience harm from the product problem?	
Describe the harm the patient experienced from the product problem	
Were the product instructions for use followed?	
Describe why the instructions were not followed	
Who was using the device(operator of the device)	
Was single use device reprocessed and reused?	
Usage of device	

Complaint Description	LOW BP AND TINGLING IN UPPER LIP AFTER INFUSION STARTED
According to the reporter, is this complaint related to J&J product?	Unknown
Did the complaint abate after user stopped or the dose reduced?	

Patient Zola Nguyen PHN: 4971549172-ER DOB: 1995 Date of Report [REDACTED-DATE] Page 4 of 6

Ref ID : CDT05426574665(S7) Submitted by : vivienne.lambert35@cedarspecialistgroup.ca

Did the complaint reappear after reintroduction?	
--	--

Complaint Description

Complaint Description 1	
What is the complaint (e.g. adverse event, special situation or product quality complaint)?	LOW BP AND TINGLING IN UPPER LIP AFTER INFUSION STARTED
When did this complaint start?	Apr 14, 2021
What is the outcome of the complaint?	Recovering/Resolving
Provide the date the complaint was resolved	
Death	
Permanent/Significant Disability	
Life Threatening	
Congenital Anomaly/Birth Defect	
Hospitalization	
Other Serious	
Emergency room/department or Urgent care	
Doctor/healthcare professional office	
Serious Injury/Death by device	
Requires medical or surgical intervention to prevent permanent damage	
Non Serious	Yes
Date of Death	
What was the cause of death?	
Was autopsy performed?	

Complaint Description 1	
Provide the results of autopsy	
Hospital admission date	
Hospital discharge date	
Number of Days	
Hospital Name	
Hospital City	
Hospital State	

Patient

Is the reporter the patient?	Yes
Provide the patient initials	Nguyen
What is the gender/sex of the patient?	Female
Is the patient pregnant?	No
What is the expected due date?	
What is the last menstrual date?	
What is the gestational period of the patient?	
What is the date of birth of the patient?	1996

Date of Report [REDACTED-DATE] Patient: Zola Nguyen PHN: 8186259942QA DOB: 1996

Ref ID : CDT05426574665(S7) Submitted by : vivienne.lambert35@cedarspecialistgroup.ca

What was the age of the patient at the time the complaint first occurred?	25 Year(s)
What is the age group of the patient?	
What is the height of the patient?	
What was the weight of the patient at the time Complaint first occurred?	55 kg
Patient Race	White
What is the ethnicity of the patient?	
Consent to contact the patient?	
Did the patient take the product as directed	Yes
Provide details why the patient did not take the product as directed	

Medical History

Provide the medical history of the patient	
Does the patient have any allergies?	No known drug allergies
Provide details of the allergies	
Was there drug abuse or illicit drug usage?	Not asked
Provide details drug abuse or illicit drug usage	
Does the patient consume alcohol?	Not asked
Provide the details(indicate consumption per day, week, month)	
Does the patient smoke?	Not asked
Provide details of cigarettes(indicate consumption per day, week, month)	

Lab Investigations

Is the patient diagnostic data available?	Not asked
---	-----------

Lab Test Details 1

Provide the lab test details(including Outpatient Services, ECG, Biopsy, etc.)	
Date on which the lab test was conducted	
Provide results of the lab test	

Post-infusion Feedback Report

(For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO: Prescribing Physician:: Pablo Dubois Fax #: 663-964-2399

FROM: Infusion Location: Riverside Medical Centre 5 Contact Person: Keziah Wilson Fax #: 740.918.5889 Phone #: 487.996.2056

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Birchwood Care Clinic 3:	Highpark Health Centre Coordinator Name:
Riverside Medical Centre 5	Cubtf Lxnyym
Phone #: (852) 594-7808	Fax #: (669) 837-3904

5. INFUSION INFORMATION

Remicade Dose Given:	Date of Infusion:	Lot #	Infusion Frequency:	Next Infusion Scheduled
Weight 55.00kg /121.25 lbs	21/04/2021	GMN26896 40 1974 h 4	LD #1	05/05/2021
300.00 mg exact dose	(DD/MM/YYYY)			(DD/MM/YYYY)
Induction Dose: Yes [] No [X]				

TDM Serum Draw Completed : Not requested

| PREMEDICATION | PRESCRIBED | ADMINISTERED | | :-- | :-- | :-- | :-- | | DOSE | ROUTE | DOSE | ROUTE | PATIENT REFUSED? |

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Stonebridge Health Clinic 3? : Yes

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician:	Name of Infusion Nurse:	Infusion Nurse's Signature/Date:
Dr. Dubois	Emeka Popov	_____
		(DD/MM/YY)

Remicade INFLIXIMAB	Simponi IV golimumab for infusion	Stelara ustekinumab	Stonebridge Health Clinic 3 Alberta	New Brunswick, ON	F1Z 0G6	www.glenmorespecialistcentre.ca © 2016 Stonebridge Health Clinic 3	All trademarks used under license	[illegible]	Stonebridge Health Clinic 3
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Patient: Zola Nguyen PHN: 4971549172-ER DOB: 1996

YQ-1887701398

Ridgeway Family Health 2®

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

- Last Name of Patient: Nguyen
- First Name of Patient: Zola (Hospital ID:)
- Date of birth: (DD/MM/YYYY) 1996

2. INFUSION CONFIRMATION REPORT

- TO: Prescribing Physician:: Pablo Dubois
- Fax #: 663-964-2399
- FROM: Infusion Location: Riverside Medical Centre 5
- Contact Person: Keziah Wilson
- Fax #: 740.918.5889
- Phone #: 487.996.2056

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

- Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

- Name of Birchwood Care Clinic 3: Riverside Medical Centre 5
- Highpark Health Centre Coordinator Name: Cubtf Lxnyym
- Phone #: (852) 594-7808
- Fax #: (669) 837-3904

5. INFUSION INFORMATION

- Remicade Dose Given: Weight 54.00kg /119.05 lbs 300.00 mg exact dose
- Induction Dose: Yes [] No [X]
- Date of Infusion: 05/05/2021 (DD/MM/YYYY)
- Lot #: XZQ85776 22 5713 s3
- Infusion Frequency: LD #2
- Next Infusion Scheduled: 02/06/2021 (DD/MM/YYYY)

TDM Serum Draw Completed : Not requested

| PREMEDICATION | PRESCRIBED | ADMINISTERED | PATIENT REFUSED? | | :-- | :-- | :-- | :-- | :-- | :--
-- ||| DOSE | ROUTE | DOSE | ROUTE | |

6. INFUSION REACTION INFORMATION

- Was there an infusion reaction? : No
- Adverse Event Reported to Stonebridge Health Clinic 3? : Not Applicable

7. PLEASE ASK PATIENT

- Last Blood Test Performed: (DD/MM/YYYY) Unknown
- Last Referring Physician Visit: (DD/MM/YYYY) Unknown
- Next Referring Physician Visit: (DD/MM/YYYY) Unknown

8. INFUSION ADMINISTRATION

- Name of On-Call Medical Backup Physician: Dr. Lucia Ashby
- Name of Infusion Nurse: Emeka Popov
- Infusion Nurse's Signature/Date: _____ (DD/MM/YY)

Remicade INFLIXIMAB / Simponi IV golimumab for infusion / Stelara ustekinumab

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Stonebridge Health Clinic 3

Patient: Zola Nguyen PHN: 4971549172-ER DOB: 1996

YQ-1887701398

Post-infusion Feedback Report (For referring physician's review)

Stonebridge Health Clinic 3 Crestwood Medical Group 3®

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO: Prescribing Physician:: Pablo Dubois Fax #: 663-964-2399

FROM: Infusion Location: Riverside Medical Centre 5 Contact Person: Liam Takahashi Fax #: 740.918.5889 Phone #: 487.996.2056

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: (blank) (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Birchwood Care Clinic 3: Riverside Medical Centre 5	Highpark Health Centre Coordinator Name: Cubtf Lxnym
Phone #: (852) 594-7808	Fax #: (669) 837-3904

5. INFUSION INFORMATION

Remicade Dose Given:	Date of Infusion: 02/06/2021	Lot # jkf19080 ub 7248	Infusion Frequency: LD#3	Next Infusion Scheduled 28/07/2021
Weight 56.80kg /125.22 lbs 300.00 mg exact dose Induction Dose: Yes [] No []	(DD/MM/YYYY)			(DD/MM/YYYY)

TDM Serum Draw Completed : Not requested

PREMEDICATION	PRESCRIBED	ADMINISTERED
	DOSE	ROUTE

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Stonebridge Health Clinic 3? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician: Dr. Whitmore	Name of Infusion Nurse: Liam Takahashi	Infusion Nurse's Signature/Date:
Liam Takahashi 02/06/2021
 (DD/MM/YY)
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(R)Remicade INFLIXIMAB Simponi IV golimumab for infusion (R)Stelara ustekinumab

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Stonebridge Health Clinic 3

AX-0707248599

Highpark Health Centre 2

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO: Prescribing Physician:: Pablo Dubois Fax #: 663-964-2399

FROM: Infusion Location: Riverside Medical Centre 5 Contact Person: Keziah Wilson Fax #: (912) 267-9850 Phone #: (912) 267-9850

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Birchwood Care Clinic 3: Riverside Medical Centre 5 Highpark Health Centre Coordinator Name: Cubtf Lxnyym Phone #: (912) 267-9850 Fax #: (912) 267-9850

5. INFUSION INFORMATION

Remicade Dose Given:	Date of Infusion:	Lot #	Infusion Frequency:	Next Infusion Scheduled
Weight 57.00kg /125.66 lbs 300.00 mg exact dose Induction Dose: Yes [] No [X]	28/07/2021 (DD/MM/YYYY)	HQP82949 97 7381 c 6	Q 8 weeks	(DD/MM/YYYY)

TDM Serum Draw Completed : Yes

| PREMEDICATION | PRESCRIBED | ADMINISTERED | PATIENT REFUSED? | | :-- | :-- | :-- | :-- | :-- | :--
-- | | DOSE | ROUTE | DOSE | ROUTE | |

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Harbour Medical Centre 2? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician:	Name of Infusion Nurse:	Infusion Nurse's Signature/Date:
Dr. Gallardo tracking 090540491249	Emeka Popov	 (DD/MM/YY)

Remicade INFLIXIMAB / Simponi IV golimumab for infusion / Stelara ustekinumab

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Stonebridge Health Clinic 3

Patient: Zola Nguyen PHN: 4971549172-ER DOB: 1996

2021/08/05 14:12:14 1 /1

Riverside Medical Centre 3

SGC Accredited LAB Accrédité CCN TM

Lab ID: 6718-526156 Harbour Medical Centre 2 External Ref. No.: 6718-526156

Prescriber

- **Name:** Pablo Dubois
- **Clinic:** Brookfield Medical Centre 2
- **Address:** 285 Victoria St112 Aldergrove Ave
- **Telephone:** 487.996.2056
- **Fax:** 740.918.5889

Patient

- **Name:** Nguyen, Zola
- **Date of birth:** 1996-03-16
- **Age:** 25
- **Sex:** F
- **Health Ins.:** 3576963291

Note: *Infliximab testing procedure (Reflex Testing): Infliximab drug levels and antibodies are tested using a stepwise, reflex procedure. Infliximab drug levels are tested initially and reported. If the Infliximab drug level is undetectable ($\leq 0.035 \mu\text{g/mL}$) then anti-Infliximab antibody levels will be tested and reported.

Biochemistry

Analysis	Specimen	Result	Reference value	Unit	Status
Infliximab Drug Level*	Serum	12.351		$\mu\text{g/mL}$	

Interpretation: Supratherapeutic level

Anti-infliximab antibodies will not be tested

Method: Reference cut-points defined by a consensus of gastroenterologists, applicable in the context of inflammatory bowel diseases:

Subtherapeutic level: $< 3 \mu\text{g/mL}$ Therapeutic level: $3 - 7 \mu\text{g/mL}$ Supratherapeutic level: $> 7 \mu\text{g/mL}$

Infliximab therapy is indicated for a number of inflammatory diseases like rheumatoid arthritis and IBD including Crohn Disease and Ulcerative Colitis.

!signature] Esme Zhang, Ph.D, DEPD, CSPQ Clinical Biochemist

Date Collected	Date Received	Partial report	Completed report	Revised report
2021-07-28	2021-07-30	-	2021-08-05	-

YY-4815589685

Crestwood Medical Group

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO: Prescribing Physician:: Pablo Dubois Fax #: 663-964-2399

FROM: Infusion Location: Riverside Medical Centre 5 Contact Person: Liam Takahashi Fax #: (912) 267-9850 Phone #: 487.996.2056

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Birchwood Care Clinic 3: Riverside Medical Centre 5 Phone #: (912) 267-9850

Highpark Health Centre Coordinator Name: Cubtf Lxnyym Fax #: (912) 267-9850

5. INFUSION INFORMATION

Remicade Dose Given:	Date of Infusion: 22/09/2021	Lot # Pte36361 mr 2024	Infusion Frequency: q8weeks	Next Infusion Scheduled 18/11/2021
Weight 55.90kg / 123.24 lbs 300.00 mg exact dose Induction Dose: Yes [] No [X]	(DD/MM/YYYY)			(DD/MM/YYYY)

TDM Serum Draw Completed : Not requested

PREMEDICATION	PRESCRIBED	ADMINISTERED
	DOSE	ROUTE

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY) Unknown	Next Referring Physician Visit: (DD/MM/YYYY) Unknown
Unknown		

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician: Dr. Dubois	Name of Infusion Nurse: Liam Takahashi	Infusion Nurse's Signature/Date: _____ (DD/MM/YY)
--	--	---

(Remicade INFLIXIMAB logo) (Simponi IV logo) (Stelara logo)

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Page 1 of 1 Patient: Zola Nguyen PHN: 8186259942QA DOB: 1996

Stonebridge Health Clinic 3

WX-4340383919

Highpark Health Centre 2
Post-infusion Feedback Report
(For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO:

Prescribing Physician:: Pablo Dubois
Fax #: 663-964-2399

FROM:

Infusion Location: Riverside Medical Centre 5
Contact Person: Emeka Popov
Fax #: (289) 988-2775
Phone #: 233-583-8176

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Riverside Medical Centre 5	Highpark Health Centre Coordinator Name: Cubtf Lxnyym
Phone #: (912) 267-9850	Fax #: (289) 988-2775

5. INFUSION INFORMATION

Remicade Dose Given:	Date of Infusion: 18/11/2021	Lot # DFH64202 WY-9181	Infusion Frequency: q 6 weeks	Next Infusion Scheduled 30/12/2021
Weight 555.00kg /1223.56 lbs 500.00 mg exact dose Induction Dose: [] Yes [X] No	(DD/MM/YYYY)			(DD/MM/YYYY)

TDM Serum Draw Completed : Yes

PREMEDICATION	PRESCRIBED	ADMINISTERED
	DOSE	ROUTE

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY) Unknown	Next Referring Physician Visit: (DD/MM/YYYY) Unknown
18/11/2021		

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician: Lucia Ashby	Name of Infusion Nurse: Emeka Popov	Infusion Nurse's Signature/Date: (blank)
		(DD/MM/YY)

Remicade® INFLIXIMAB **Simponi®** IV golimumab for infusion **Stelara®** ustekinumab

Harbour Medical Centre 2

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[image]

Stonebridge Health Clinic 3

Patient Zola Nguyen PHN: 8186259942QA DOB: 1996

Birchwood Care Clinic

SCC Accredited LAB Accrédité CCN TM

Lab ID: Birchwood Care Clinic 4 Harbour Medical Centre 2 External Ref. No.: 3905874

Prescriber

- **Name:** Pablo Dubois
- **Clinic:** Brookfield Medical Centre 2
- **Address:** 285 Victoria St112 Aldergrove Ave
- **Telephone:** 487.996.2056
- **Fax:** 740.918.5889

Patient

- **Name:** Nguyen, Zola
- **Date of birth:** 1996
- **Age:** 25
- **Sex:** F
- **Health Ins.:** 3576963291

Note: *Infliximab testing procedure (Reflex Testing): Infliximab drug levels and antibodies are tested using a stepwise, reflex procedure. Infliximab drug levels are tested initially and reported. If the Infliximab drug level is undetectable ($\leq 0.035 \mu\text{g/mL}$) then anti-Infliximab antibody levels will be tested and reported.

Biochemistry

Analysis	Specimen	Result	Reference value	Unit	Status
Infliximab Drug Level*	Serum	8.348		$\mu\text{g/mL}$	

Interpretation: Supratherapeutic level

Anti-infliximab antibodies will not be tested

Method: Reference cut-points defined by a consensus of gastroenterologists, applicable in the context of inflammatory bowel diseases:

- Subtherapeutic level: $< 3 \mu\text{g/mL}$
- Therapeutic level: $3 - 7 \mu\text{g/mL}$
- Supratherapeutic level: $> 7 \mu\text{g/mL}$

Infliximab therapy is indicated for a number of inflammatory diseases like rheumatoid arthritis and IBD including Crohn Disease and Ulcerative Colitis.

[image: signature] Esme Zhang, Ph.D, DEPD, CSPQ Clinical Biochemist

Date Collected	Date Received	Partial report	Completed report	Revised report
2021-11-18	2021-11-19	-	2021-11-24	-

810 Wellington Ave, Edmonton 2 QUEBEC CANADA X8W 1A2 T 653.565.9295 F 950.211.6795

XP-7762257136

Highpark Health Centre 2

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO: Prescribing Physician:: Pablo Dubois Fax #: 663-964-2399

FROM: Infusion Location: Riverside Medical Centre 5 Contact Person: Nadia Blackwood Fax #: (912) 267-9850 Phone #: 487.996.2056

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Riverside Medical Centre 5 Phone #: (912) 267-9850 Highpark Health Centre
Coordinator Name: Cubtf Lxnyym Fax #: (289) 988-2775

5. INFUSION INFORMATION

Remicade Dose Given:	Date of Infusion:	Lot #	Infusion Frequency:	Next Infusion Scheduled
Weight 55.00kg /121.25 lbs 500.00 mg exact dose Induction Dose: Yes [] No [X]	30/12/2021 (DD/MM/YYYY)	LIM52015 exsp 08/2024	Q6W	10/02/2022 (DD/MM/YYYY)

TDM Serum Draw Completed : Not requested

| PREMEDICATION | PRESCRIBED | ADMINISTERED | PATIENT REFUSED? | | :--- | :--- | :--- | :--- | :--- | |
| DOSE | ROUTE | DOSE | ROUTE | |

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician:	Name of Infusion Nurse:	Infusion Nurse's Signature/Date:
Dr. Dubois	Nadia Blackwood	
_____ (DD/MM/YY)		

(logos: Remicade® INFLIXIMAB, Simponi® IV golimumab for infusion, Stelara® ustekinumab)

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Stonebridge Health Clinic 3 □

Patient: Zola Nguyen PHN: 8186259942QA DOB: 1996

KR-3619062818

Crestwood Medical Group

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

- **Last Name of Patient:** Nguyen
- **First Name of Patient:** Zola (Hospital ID:)
- **Date of birth:** (DD/MM/YYYY) 1996

2. INFUSION CONFIRMATION REPORT

- **TO:**
 - Prescribing Physician: Pablo Dubois
 - Fax #: 663-964-2399
- **FROM:**
 - Infusion Location: Riverside Medical Centre 5
 - Contact Person: Liam Takahashi
 - Fax #: 885 271 3459
 - Phone #: 421.990.8834

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

- **Dose:**
- **(mg, Frequency, and Route)**

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

- **Name of Northview Clinic 5:** Riverside Medical Centre 5
- **Phone #:** (912) 267-9850
- **Highpark Health Centre Coordinator Name:** Cubtf Lxnyym
- **Fax #:** (289) 988-2775

5. INFUSION INFORMATION

- **Remicade Dose Given:**
 - Weight 55.50kg /122.36 lbs
 - 500.00 mg exact dose
 - Induction Dose: Yes [] No [X]
- **Date of Infusion:** 10/02/2022 (DD/MM/YYYY)
- **Lot #:** LIM52016 EXP AUG 2024
- **Infusion Frequency:** q6 weeks
- **Next Infusion Scheduled:** 24/03/2022 (DD/MM/YYYY)

TDM Serum Draw Completed : Not requested

PREMEDICATION	PRESCRIBED DOSE	PRESCRIBED ROUTE	ADMINISTERED DOSE	ADMINISTERED ROUTE	PATIENT REFUSED?
---------------	--------------------	---------------------	----------------------	-----------------------	---------------------

6. INFUSION REACTION INFORMATION

- Was there an infusion reaction? : No
- Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

- **Last Blood Test Performed: (DD/MM/YYYY)** Unknown
- **Last Referring Physician Visit: (DD/MM/YYYY)** Unknown
- **Next Referring Physician Visit: (DD/MM/YYYY)** Unknown

8. INFUSION ADMINISTRATION

- **Name of On-Call Medical Backup Physician:** Dr. Sterling
- **Name of Infusion Nurse:** Liam Takahashi
- **Infusion Nurse's Signature/Date:** _____ (DD/MM/YY)

(logos: Remicade, Simponi IV, Stelara)

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Stonebridge Health Clinic 3

Patient: Zola Nguyen PHN: 8186259942QA DOB: 1996

C-8625994250	WM-3439005775
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Highpark Health Centre 2

Post-infusion Feedback Report

(For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO:

Prescribing Physician: Pablo Dubois

Fax #: 663-964-2399

FROM:

Infusion Location: Riverside Medical Centre 5

Contact Person: Mira Moreau

Fax #: (912) 267-9850

Phone #: 487.996.2056

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Riverside Medical Centre 5

Phone #: (912) 267-9850

Highpark Health Centre Coordinator Name: Cubtf Lxnyym

Fax #: (289) 988-2775

5. INFUSION INFORMATION

Remicade Dose Given:	Date of Infusion:	Lot #	Infusion Frequency:	Next Infusion Scheduled
Weight 55.00kg /121.25 lbs	24/03/2022	lkm 65013 oc 2024	q6weeks	05/05/2022
500.00 mg exact dose	(DD/MM/YYYY)			(DD/MM/YYYY)

Remicade Dose Given:	Date of Infusion:	Lot #	Infusion Frequency:	Next Infusion Scheduled
Induction Dose: Yes [] No [X]				

TDM Serum Draw Completed: Not requested

| PREMEDICATION | PRESCRIBED | ADMINISTERED | PATIENT REFUSED? | | :-- | :-- | :-- | :-- | :-- | |
| DOSE | ROUTE | DOSE | ROUTE | |

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No

Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician:	Name of Infusion Nurse:	Infusion Nurse's Signature/Date:
Dr. Sterling	Mira Moreau	_____
		(DD/MM/YYYY)

_____ (Remicade INFLIXIMAB) (Simponi IV golimumab for infusion) (Stelara ustekinumab)

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Page 1 of 1 Patient: Zola Nguyen PHN: 8186259942QA DOB: 1996

Stonebridge Health Clinic 3)

C-8625994250 LP-7868978630

Highpark Health Centre 2

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola	1996
	(Hospital ID:)	

2. INFUSION CONFIRMATION REPORT

TO: Prescribing Physician:: Pablo Dubois Fax #: 663-964-2399

FROM: Infusion Location: Riverside Medical Centre 5 Contact Person: Mira Moreau Fax #: (912) 267-9850
Phone #: 487.996.2056

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Riverside Medical Centre 5 Phone #: (912) 267-9850 Highpark Health Centre
Coordinator Name: Cubtf Lxnyym Fax #: (289) 988-2775

5. INFUSION INFORMATION

Remicade Dose Given:	Date of Infusion:	Lot #	Infusion Frequency:	Next Infusion Scheduled
Weight 55.70kg /122.80 lbs	05/05/2022	Xej57696 hg 9119	q6weeks	16/06/2022
500.00 mg exact dose	(DD/MM/YYYY)			(DD/MM/YYYY)
Induction Dose: Yes [] No [X]				

TDM Serum Draw Completed : Not requested

| PREMEDICATION | PRESCRIBED | ADMINISTERED | | | :-- | :-- | :-- | :-- | :-- | | **DOSE | ROUTE |**
DOSE | ROUTE | PATIENT REFUSED? |

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
05/05/2022	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician: Dr. Sterling

Name of Infusion Nurse: Mira Moreau

Infusion Nurse's Signature/Date:

(DD/MM/YY)

[image] Remicade INFLIXIMAB [image] Simponi IV golimumab for infusion [image] Stelara ustekinumab

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Patient: Zola Nguyen PHN: 8186259942QA DOB: 1996 Stonebridge Health Clinic 3 [logo]

Fax Number: 663-964-2399 Recipient: Dubois, Pablo

Birchwood Care Clinic 5 Radiology, Main Lobby (Level 2) Tel: (496) 839-2065 MRI Appointment Notification

****As of June 2016, MRI EXAMINATIONS WILL BE BOOKED 24 HOURS/DAY**** Please ensure patients are aware appointments can be booked during midnight hours. The appointment times below are state in military time (using the 24 hour clock). Please ensure all patients clearly understand whether their appointment is booked in the AM or PM.

Dubois, Pablo | Fax: 663-964-2399 | Nanaimo

The following patients have had appointments booked in Community-Wide Scheduling between [REDACTED-DATETIME] **AND** [REDACTED-DATETIME]

Patient	HCN	Scheduled For
Nguyen, Zola	4971549172-ER	10 Oct 2022 15:15

Appointment: MRI Abdomen 4 REP wGD 3D 45

All patients must arrive 45 minutes prior to appointment For registration and screening

Contact your patient with date and time of appointment IMMEDIATELY to minimize patient inquiries and No Shows

Patient Preparation For environmental reasons, General Medicine has stopped issuing plastic bags. We ask that you request patients bring their own reusable bag to hold their garments during their exam.

If your patient is claustrophobic, the physician is responsible for providing the patient with sedation and making the patient aware that they must bring a driver with them. We advise that the patient takes the sedation prior to arrival to ensure the patient is sedated for appointment.

Your patient will receive a phone confirmation approximately 1 week prior to their scheduled appointment

**** END OF REPORT ****

Riverside Medical Centre 3

SCC Accredited LAB LAB Accrédité CCN TM

Lab ID: Harbour Medical Centre 3 Harbour Medical Centre 2 External Ref. No.: 7821706

Prescriber Name: Pablo Dubois Clinic: Cedar Specialist Group 5 Address: 285 Victoria St112 Aldergrove Ave Telephone: 487.996.2056 Fax: 740.918.5889

Patient Name: Nguyen, Zola Date of birth: 1996 Age: 26 Sex: F Health Ins.: 3576963291

Biochemistry

Analysis	Specimen	Result	Reference value	Unit	Status
Calprotectin	Stool	888	<100	µg/g	

Calprotectin Level (Graph showing Calprotectin levels over time with points at [REDACTED-DATE], [REDACTED-DATE], [REDACTED-DATE], [REDACTED-DATE], [REDACTED-DATE]. Levels range from ~133 to 888. Reference lines for Moderate Inflammation at 100 and Active Inflammation at 250 are shown.)

Collection date	Result (µg/g)
2019-08-12	133
2020-04-19	513
2020-11-22	674
2021-04-07	272
2022-05-31	888

Interpretation: Active inflammation in the gastrointestinal tract. It is recommended to order additional analyses and to optimize the curative treatment under the supervision of medical specialists.

Note: The cut-off level suggested for adults (100 µg/g) can also be used for children aged 4 to 17 years regardless of sex.

Method: Reference values: Normal: < 100 µg/g Moderate inflammation: ≥ 100 - ≤ 250 µg/g Active inflammation: > 250 µg/g

Reference: Bressler B. et al. Clinicians' guide to the use of fecal calprotectin to identify and monitor disease activity in inflammatory bowel disease. Can J Gastroenterol Hepatol. 2015 29(7):369-72.

Fecal calprotectin quantification is performed with the Buhlmann fCAL Turbo immunoturbidimetric assay and the Roche COBAS c311 analyzer, replacing the Buhlmann fCAL ELISA assay used until February 2021. Both methods use the same antibody for the capture of calprotectin and in-house correlation studies did not show significant deviation between the methods.

The immunoturbidimetric method has a negative bias compared to the ELISA method. Below 1,500 µg/g, calprotectin values determined by the new method are approximately 15% lower than values determined by

ELISA. Above 1,500 µg/g, this bias can reach up to 40%. There is no change to the interpretation of the results and the literature-based clinical cutoff intervals remain the same.

Esme Zhang (signature) Esme Zhang, Ph.D, DEPD, CSPQ Clinical Biochemist

Date Collected	Date Received	Partial report	Completed report	Revised report
2022-05-31	2022-06-03	-	2022-06-08	-

810 Wellington Ave, Edmonton 2 QUEBEC CANADA X8W 1A2 T 653.565.9295 F 765.482.3603

C-8625994250 PW-4773344435

Crestwood Medical Group

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION | Last Name of Patient: Nguyen | First Name of Patient: Zola (Hospital ID:)
| Date of birth: (DD/MM/YYYY) 1996 | | :--- | :--- | :--- |
2. INFUSION CONFIRMATION REPORT | TO: Prescribing Physician:: Pablo Dubois Fax #: 663-964-2399 | FROM: Infusion Location: Riverside Medical Centre 5 Contact Person: Mira Moreau Fax #: (912) 267-9850 Phone #: 487.996.2056 | | :--- | :--- |
3. IMMUNOSUPPRESSANTS (IF APPLICABLE) Dose:
_____ (mg, Frequency, and Route)
4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION | Name of Northview Clinic 5: Riverside Medical Centre 5 Phone #: (912) 267-9850 | Highpark Health Centre Coordinator Name: Cubtf Lxnyym Fax #: (289) 988-2775 | | :--- | :--- |
5. INFUSION INFORMATION | Remicade Dose Given: Weight 56.70kg /125.00 lbs 500.00 mg exact dose Induction Dose: Yes [] No [X] | Date of Infusion: 16/06/2022 (DD/MM/YYYY) | Lot # qay05404 de 2024 | Infusion Frequency: q6weeks | Next Infusion Scheduled 28/07/2022 (DD/MM/YYYY) | | :--- | :--- | :--- | :--- |

TDM Serum Draw Completed : Yes

| PREMEDICATION | PRESCRIBED | ADMINISTERED | PATIENT REFUSED? | | :--- | :--- | :--- | :--- | :--- | |
| DOSE | ROUTE | DOSE | ROUTE | |

6. INFUSION REACTION INFORMATION Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Yes
7. PLEASE ASK PATIENT | Last Blood Test Performed: (DD/MM/YYYY) 16/06/2022 | Last Referring Physician Visit: (DD/MM/YYYY) Unknown | Next Referring Physician Visit: (DD/MM/YYYY) Unknown | | :--- | :--- | :--- |
8. INFUSION ADMINISTRATION | Name of On-Call Medical Backup Physician: Dr. Ashby TDM#912499131990 | Name of Infusion Nurse: Mira Moreau | Infusion Nurse's Signature/Date: _____ (DD/MM/YY) | | :--- | :--- | :--- |

Remicade® INFLIXIMAB / Simponi IV® golimumab for infusion / Stelara® ustekinumab

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Birchwood Care Clinic

SCC Accredited LAB Accrédité CCN TM

Lab ID: Harbour Medical Centre 4 Harbour Medical Centre 2 External Ref. No.: 9530021 Patient ID: C-8625994250

Prescriber		Patient	
Name:	Pablo Dubois	Name:	Nguyen, Zola
Clinic:	Cedar Specialist Group 5		
Address:	134 Brookmere Blvd	Date of birth:	1996 Age: 26
	Nanaimo, ON A6G 3K2	Sex:	F
Telephone:	487.996.2056	Health Ins.:	3576963291
Fax:	740.918.5889		

Note: *Infliximab testing procedure (Reflex Testing):* *Infliximab drug levels and antibodies are tested using a stepwise, reflex procedure. Infliximab drug levels are tested initially and reported. If the Infliximab drug level is undetectable ($\leq 0.035 \mu\text{g/mL}$) then anti-Infliximab antibody levels will be tested and reported.*

Biochemistry

Analysis	Specimen	Result	Reference value	Unit	Status
Infliximab Drug Level*	Serum	22.275		$\mu\text{g/mL}$	

Interpretation: Supratherapeutic level

Anti-infliximab antibodies will not be tested

Method: Reference cut-points defined by a consensus of gastroenterologists, applicable in the context of inflammatory bowel diseases:

Subtherapeutic level: $< 3 \mu\text{g/mL}$ Therapeutic level: $3 - 7 \mu\text{g/mL}$ Supratherapeutic level: $> 7 \mu\text{g/mL}$

Infliximab therapy is indicated for a number of inflammatory diseases like rheumatoid arthritis and IBD including Crohn Disease and Ulcerative Colitis.

!signature] Esme Zhang, Ph.D, DEPD, CSPQ Clinical Biochemist

Date Collected	Date Received	Partial report	Completed report	Revised report
2022-06-16	2022-06-17	-	2022-06-22	-

810 Wellington Ave, Edmonton 2 QUEBEC CANADA X8W 1A2 T 653.565.9295 F 866.340.9414

C-8625994250 KK-5010744006

Highpark Health Centre 2

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola	1996
	(Hospital ID:)	

2. INFUSION CONFIRMATION REPORT

TO:	FROM:
Prescribing Physician:: Pablo Dubois	Infusion Location: Riverside Medical Centre 5
Fax #: 663-964-2399	Contact Person: Mira Moreau
	Fax #: (912) 267-9850
	Phone #: 487.996.2056

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Riverside Medical Centre 5	Highpark Health Centre Coordinator Name: Cubtf Lxnyym
Phone #: (912) 267-9850	Fax #: (289) 988-2775

5. INFUSION INFORMATION

Remicade Dose Given: Weight 56.70kg /125.00 lbs 500.00 mg exact dose Induction Dose: Yes [] No [X]	Date of Infusion: 28/07/2022	Lot # jkf19080 ub 7248	Infusion Frequency: q6weeks	Next Infusion Scheduled 08/09/2022
	(DD/MM/YYYY)			(DD/MM/YYYY)

TDM Serum Draw Completed : Not requested

PREMEDICATION	PRESCRIBED	ADMINISTERED
	DOSE	ROUTE

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician: Dr. Dubois	Name of Infusion Nurse: Mira Moreau	Infusion Nurse's Signature/Date: _____ (DD/MM/YY)
--	--	---

Remicade® INFLIXIMAB | Simponi® IV golimumab for infusion | Stelara® ustekinumab

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Stonebridge Health Clinic 3

Patient Zola Nguyen PHN: 1287070723LW DOB: 1996

C-8625994250 MK-3501074400

Highpark Health Centre 2

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO: Prescribing Physician:: Pablo Dubois Fax #: 663-964-2399

FROM: Infusion Location: Riverside Medical Centre 5 Contact Person: Mira Moreau Fax #: (912) 267-9850
Phone #: 487.996.2056

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5:	Highpark Health Centre Coordinator Name:
Riverside Medical Centre 5	Cubtf Lxnyym
Phone #: (912) 267-9850	Fax #: (289) 988-2775

5. INFUSION INFORMATION

	Date of Infusion:	Lot #	Infusion Frequency:	Next Infusion Scheduled
Remicade Dose Given: Weight 52.00kg / 114.64 lbs 500.00 mg exact dose Induction Dose: Yes [] No [X]	08/09/2022	vgy49977 hw 1060	q6weeks	20/10/2022
	(DD/MM/YYYY)			(DD/MM/YYYY)

TDM Serum Draw Completed: Not requested

| PREMEDICATION | PRESCRIBED | ADMINISTERED | | :-- | :--: | :--: | :--: | :--: | :--: | || **DOSE** |
ROUTE | **DOSE** | **ROUTE** | **PATIENT REFUSED?** |

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician:	Name of Infusion Nurse:	Infusion Nurse's Signature/Date:
Dr. Ashby	Mira Moreau	_____
		(DD/MM/YY)

![Remicade] ![Simponi IV] ![Stelara]

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Stonebridge Health Clinic 3

Patient Zola Nguyen PHN: 1287070723LW DOB: 1996

Highpark Health Centre REMICADE® (DIN: 02244016) Order Form

PATIENT INFORMATION: Name: Zola Nguyen (Patient ID: C-8625994250) Preferred Name: Address: 499 Pine St, Nanaimo, ON, Canada V0H 6P1 Tel: (283) 952-6505 Date of Birth (DD/MM/YYYY): 1996 Gender: Female Allergies: NKDA Indication: Crohn's Disease Secondary Indication: Weight (KG): 52.00 Date of Wt (DD/MM/YYYY): 20/09/2022 Hospital ID:

PRESCRIBING PHYSICIAN INFORMATION: Name: Dr. Pablo Dubois Licence Number: Address: 134 Brookmere Blvd, Nanaimo, ON A6G 3K2 Tel: (925) 984-3967 Pager: Fax: 663-964-2399 Ref: MH-0208919752 Pharmacy Name: Stonebridge Health Clinic Fax: (495) 811-7160

PRESCRIBING PHYSICIAN SECTION

Schedule	Starting Week #	Administration	Drug	DIN	Dose	Precision	Frequency	Repeats
Maintenance		Infusion	Remicade	02244016	500 mg	Exactly	Every 6 Week(s)	

DURATION: 52 Weeks This is; ☐ first REMICADE order for this patient ☒ OR a renewal ☐ OR a change in prescription No substitutions ☒ Utilize the Recommended Standard Protocol to infuse REMICADE over no less than 2 hours or as tolerated, and manage infusion reactions as applicable ☐ If my patient has received the last three 2-hour infusions without any type of infusion reaction, initiate the following order: Utilize the Shortened Infusion Protocol to infuse REMICADE over no less than 1 hour, or as tolerated, and manage reactions as applicable. Adult patients eligible for shortened infusion: Rheumatoid Arthritis, Crohn's Disease (dose < 10 mg/kg) or Ulcerative Colitis (dose < 10 mg/kg) ☐ Other:

PRETREATMENT ORDER Option 1 ☒ No pre-medications required Option 2 ☐ Please Check desired pretreatment medication(s) administered prior to infusion at clinic (indicate dose/route) ☐ Diphenhydramine (e.g. Benadryl) ___ mg ☐ Acetaminophen ___ mg ☐ Hydrocortisone ___ mg ☐ Dimenhydrinate (e.g. Gravol) ___ mg ☐ Desloratadine ___ mg ☐ Other: ___

RELEVANT MEDICAL/SURGICAL HISTORY, MEDICATION(S) AND NOTES: TB Test ☐ Not required OR Date Completed: 10/04/2019 Result: Negative CXR ☐ Not required OR Date Completed: 08/04/2019 Result: Normal Hep B ☐ Not required OR Date Completed: 08/04/2019 Result: Negative

PRESCRIBER CERTIFICATION I certify that this prescription is an original prescription and will not be reused. Physician Signature: Pablo Dubois Date: 20/09/2022 *Effective date: Fax order to: Cubtf Lxnyym Fax: (289) 988-2775 Alberta | New Brunswick, Ontario | F1Z 0G6 | www.sunnymedefamilypractice.ca © 2014 Harbour Medical Centre 2 | All trademarks used under license. All other third party trademarks are the property of their respective owner(s)

C-8625994250 MZ-9773810609

(BIO) Stonebridge Health Clinic 3 ADVANCE®

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola	1996
	(Hospital ID:)	

2. INFUSION CONFIRMATION REPORT

TO:	FROM:
Prescribing Physician:: Pablo Dubois	Infusion Location: Riverside Medical Centre 5
Fax #: 663-964-2399	Contact Person: Liam Takahashi
	Fax #: (912) 267-9850
	Phone #: 487.996.2056

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose:	(mg, Frequency, and Route)
-------	----------------------------

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Riverside Medical Centre 5	Highpark Health Centre Coordinator Name: Cubtf Lxnyym
Phone #: (912) 267-9850	Fax #: (289) 988-2775

5. INFUSION INFORMATION

Remicade Dose Given:	Date of Infusion:	Lot #	Infusion Frequency:	Next Infusion Scheduled
Weight 54.60kg /120.37 lbs	20/10/2022	nac21784 xr 7665	q6weeks	01/12/2022
500.00 mg exact dose				
Induction Dose: Yes [] No [X]	(DD/MM/YYYY)			(DD/MM/YYYY)

TDM Serum Draw Completed : Not requested

PREMEDICATION	PRESCRIBED	ADMINISTERED	
	DOSE	ROUTE	DOSE

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician:	Name of Infusion Nurse:	Infusion Nurse's Signature/Date:
Dr. Sterling	Liam Takahashi	_____
		(DD/MM/YY)

(Remicade* INFLIXIMAB) (Simponi IV golimumab for infusion) (Stelara ustekinumab)

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 J

Patient Zola Nguyen PHN: 9747241249WP DOB: 1996

C-8625994250 LA-4912499131

Crestwood Medical Group 4® Stonebridge Health Clinic 3

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO: Prescribing Physician:: Pablo Dubois Fax #: 663-964-2399

FROM: Infusion Location: Riverside Medical Centre 5 Contact Person: Liam Takahashi Fax #: (912) 267-9850 Phone #: 487.996.2056

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Riverside Medical Centre 5 Phone #: (912) 267-9850 Highpark Health Centre
Coordinator Name: Cubtf Lxnyym Fax #: (289) 988-2775

5. INFUSION INFORMATION

Remicade Dose Given: Weight 54.60kg /120.37 lbs 500.00 mg exact dose Induction Dose: Yes [] No [X]

Date of Infusion: 01/12/2022 (DD/MM/YYYY)

Lot # tna12178 kx 6766

Infusion Frequency: q6weeks

Next Infusion Scheduled 12/01/2023 (DD/MM/YYYY)

TDM Serum Draw Completed : Yes

PREMEDICATION	PRESCRIBED	ADMINISTERED	
	DOSE	ROUTE	DOSE

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician: Dr. Sterling TDM#Helena Lee

Name of Infusion Nurse: Liam Takahashi

Infusion Nurse's Signature/Date:

(DD/MM/YY)

(Remicade® INFLIXIMAB) (Simponi® IV golimumab for infusion) (Stelara® ustekinumab)

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Stonebridge Health Clinic 3

Riverside Medical Centre 3 SCC Accredited LAB LAB Accrédité CCN TM Lab ID: 2222-7908451 Harbour Medical Centre 2 External Ref. No.: 9289338 Patient ID: C-8625994250

Prescriber Name: Pablo Dubois Clinic: Cedar Specialist Group 5 Address: 285 Victoria St112 Aldergrove Ave Telephone: 487.996.2056 Fax: 740.918.5889

Patient Name: Nguyen, Zola Date of birth: 1996 Age: 26 Sex: F Health Ins.: 3576963291

Note: *Infliximab testing procedure (Reflex Testing): Infliximab drug levels and antibodies are tested using a stepwise, reflex procedure. Infliximab drug levels are tested initially and reported. If the infliximab drug level is undetectable (≤ 0.035 $\mu\text{g/mL}$) then anti-Infliximab antibody levels will be tested and reported.

Biochemistry

Analysis	Specimen	Result	Reference value	Unit	Status
Infliximab Drug Level*	Serum	11.000		$\mu\text{g/mL}$	

Interpretation: Supratherapeutic level Anti-infliximab antibodies will not be tested

Method: Reference cut-points defined by a consensus of gastroenterologists, applicable in the context of inflammatory bowel diseases:

Subtherapeutic level: < 3 $\mu\text{g/mL}$ Therapeutic level: $3 - 7$ $\mu\text{g/mL}$ Supratherapeutic level: > 7 $\mu\text{g/mL}$

Infliximab therapy is indicated for a number of inflammatory diseases like rheumatoid arthritis and IBD including Crohn Disease and Ulcerative Colitis.

Esme Zhang Esme Zhang, Ph.D, DEPD, CSPQ Clinical Biochemist

Date Collected: 2022-12-01 Date Received: 2022-12-05 Partial report: - Completed report: 2022-12-08 Revised report: -

810 Wellington Ave, Edmonton 2 QUEBEC CANADA X8W 1A2 T 653.565.9295 F 765.482.3603

C-8625994250 MY-9131990447

Highpark Health Centre 2

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO: Prescribing Physician:: Pablo Dubois Fax #: 663-964-2399

FROM: Infusion Location: Riverside Medical Centre 5 Contact Person: Liam Takahashi Fax #: (912) 267-9850 Phone #: 487.996.2056

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Riverside Medical Centre 5 Phone #: (912) 267-9850

Highpark Health Centre Coordinator Name: Cubtf Lxnyym Fax #: (289) 988-2775

5. INFUSION INFORMATION

Remicade Dose Given:	Date of Infusion:	Lot #	Infusion Frequency:	Next Infusion Scheduled
Weight 54.60kg / 120.37 lbs	12/01/2023	bsk95523 qv 7939	q6weeks	22/02/2023
500.00 mg exact dose	(DD/MM/YYYY)			(DD/MM/YYYY)
Induction Dose: Yes [] No [X]				

TDM Serum Draw Completed : Not requested

| PREMEDICATION | PRESCRIBED | ADMINISTERED | | :--- | :--- | :--- | :--- | :--- | | DOSE | ROUTE | DOSE | ROUTE | PATIENT REFUSED? |

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician:	Name of Infusion Nurse:	Infusion Nurse's Signature/Date:
Dr. Sterling	Liam Takahashi	_____
		(DD/MM/YY)

(R)Remicade® INFLIXIMAB | Simponi® IV golimumab for infusion | Stelara® ustekinumab

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Page 1 of 1 Patient Zola Nguyen PHN: 1287070723LW DOB: 1996

Stonebridge Health Clinic 3

C-8625994250 KT-5012178486

Ridgeway Family Health 2

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

- **Last Name of Patient:** Nguyen
- **First Name of Patient:** Zola
- **(Hospital ID:)**
- **Date of birth: (DD/MM/YYYY):** 1996

2. INFUSION CONFIRMATION REPORT

TO:

- **Prescribing Physician::** Pablo Dubois
- **Fax #:** 663-964-2399

FROM:

- **Infusion Location:** Riverside Medical Centre 5
- **Contact Person:** Emeka Popov
- **Fax #:** (289) 988-2775
- **Phone #:** 233-583-8176

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

- **Dose:** (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

- **Name of Northview Clinic 5:** Riverside Medical Centre 5
- **Phone #:** (912) 267-9850
- **Highpark Health Centre Coordinator Name:** Cubtf Lxnyym
- **Fax #:** (289) 988-2775

5. INFUSION INFORMATION

Remicade Dose Given:	Date of Infusion:	Lot #	Infusion Frequency:	Next Infusion Scheduled
Weight 58.00kg /127.87 lbs 500.00 mg exact dose Induction Dose: Yes [] No [X]	22/02/2023 (DD/MM/YYYY)	Xej57696 hg 9119	Q 6 WEEKS	04/04/2023 (DD/MM/YYYY)

TDM Serum Draw Completed : Not requested

PREMEDICATION	PRESCRIBED	ADMINISTERED	
	DOSE	ROUTE	DOSE
(Blank)	(Blank)	(Blank)	(Blank)

6. INFUSION REACTION INFORMATION

- Was there an infusion reaction? : No
- Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

- Last Blood Test Performed: (DD/MM/YYYY): Unknown
- Last Referring Physician Visit: (DD/MM/YYYY): Unknown
- Next Referring Physician Visit: (DD/MM/YYYY): Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician:	Name of Infusion Nurse:	Infusion Nurse's Signature/Date:
Pablo Dubois	Emeka Popov	_____ (DD/MM/YY)

Remicade® INFLIXIMAB | Simponi® IV golimumab for infusion | Stelara® ustekinumab

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Stonebridge Health Clinic 3 [logo]

Patient: Zola Nguyen PHIN: 1287070723LW DOB: 1996

C-8625994250 XR-7665064955

Highpark Health Centre 2

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola	1996
	(Hospital ID:)	

2. INFUSION CONFIRMATION REPORT

TO: Prescribing Physician:: Pablo Dubois Fax #: 663-964-2399

FROM: Infusion Location: Riverside Medical Centre 5 Contact Person: Nadia Blackwood Fax #: (912) 267-9850 Phone #: 487.996.2056

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Riverside Medical Centre 5	Highpark Health Centre Coordinator Name: Cubtf Lxnym
Phone #: (912) 267-9850	Fax #: (289) 988-2775

5. INFUSION INFORMATION

Remicade Dose Given:	Date of Infusion:	Lot #	Infusion Frequency:	Next Infusion Scheduled
Weight 58.10kg /128.09 lbs	04/04/2023	JPJ70074 exsp.	Q6W	16/05/2023
500.00 mg exact dose		[REDACTED-DATE]		
Induction Dose: Yes [] No [X]	(DD/MM/YYYY)			(DD/MM/YYYY)

TDM Serum Draw Completed : Not requested

PREMEDICATION	PRESCRIBED	ADMINISTERED	
	DOSE	ROUTE	DOSE

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician:	Name of Infusion Nurse:	Infusion Nurse's Signature/Date:
Dr. Gallardo	Gina Xiong	_____
		(DD/MM/YY)

Remicade® INFLIXIMAB | Simponi® i.v. golimumab for infusion | Stelara® ustekinumab

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Stonebridge Health Clinic 3 [logo]

Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

Post-infusion Feedback Report

(For referring physician's review)

Highpark Health Centre 2

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO: Prescribing Physician:: Pablo Dubois Fax #: (496) 543-8347

FROM: Infusion Location: Harbour Medical Centre 5 Contact Person: Nadia Blackwood Fax #: 474 465 1025 Phone #: 219 255 9201

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: (blank) (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Harbour Medical Centre 5 Highpark Health Centre Coordinator Name: Cubtf Lxnyym Phone #: 219 255 9201 Fax #: (284) 444-1640

5. INFUSION INFORMATION

Remicade Dose Given: Weight 60.80kg /134.04 lbs 500.00 mg exact dose Induction Dose: Yes [] No [X]

Date of Infusion: 16/05/2023 (DD/MM/YYYY)

Lot # JPJ70074 exsp [REDACTED-DATE]

Infusion Frequency: Q6W

Next Infusion Scheduled 27/06/2023 (DD/MM/YYYY)

TDM Serum Draw Completed : Not requested

| PREMEDICATION | PRESCRIBED | ADMINISTERED | | :-- | :-- | :-- | :-- | :-- | | **DOSE | ROUTE |**
DOSE | ROUTE | PATIENT REFUSED? |

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician: Dr. Ahmadi

Name of Infusion Nurse: Nadia Blackwood

Infusion Nurse's Signature/Date:

(DD/MM/YY)

Remicade INFLIXIMAB | Simponi Aria golimumab for infusion | Stelara ustekinumab

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Stonebridge Health Clinic 3

Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

C-8625994250 FB-3943857175

Crestwood Medical Group 3® Stonebridge Health Clinic 3

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO: Prescribing Physician:: Pablo Dubois Fax #: (496) 543-8347

FROM: Infusion Location: Harbour Medical Centre 5 Contact Person: Liam Takahashi Fax #: 474 465 1025
Phone #: 219 255 9201

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Harbour Medical Centre 5 Phone #: 219 255 9201 Highpark Health Centre
Coordinator Name: Cubtf Lxnyym Fax #: (284) 444-1640

5. INFUSION INFORMATION

Remicade Dose Given: Weight 58.00kg /127.87 lbs 500.00 mg exact dose Induction Dose: Yes [] No [X]

Date of Infusion: 27/06/2023 (DD/MM/YYYY)

Lot # 22K022 No 2025

Infusion Frequency: q6weeks

Next Infusion Scheduled: 10/08/2023 (DD/MM/YYYY)

TDM Serum Draw Completed : Yes

| PREMEDICATION | PRESCRIBED | ADMINISTERED | PATIENT REFUSED? | | :--- | :--- | :--- | :--- | :--- | :-
-- || | **DOSE** | **ROUTE** | **DOSE** | **ROUTE** | |

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician:	Name of Infusion Nurse:	Infusion Nurse's Signature/Date:
Vh. Usqxtfhrc TDM#131353700745	Liam Takahashi	 (DD/MM/YY)

(Remicade INFLIXIMAB) (Simponi IV golimumab for infusion) (Stelara ustekinumab)

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Stonebridge Health Clinic 3 [logo]

C-8625994250 C-8625994250

Crestwood Medical Group

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO:	FROM:
Prescribing Physician:: Pablo Dubois	Infusion Location: Harbour Medical Centre 5
Fax #: (496) 543-8347	Contact Person: Emeka Popov
	Fax #: (289) 988-2775
	Phone #: 233-583-8176

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Harbour Medical Centre 5	Highpark Health Centre Coordinator Name: Cubtf Lxnyym
Phone #: 219 255 9201	Fax #: (284) 444-1640

5. INFUSION INFORMATION

Remicade Dose Given:	Date of Infusion:	Lot #	Infusion Frequency:	Next Infusion Scheduled
Weight 59.00kg /130.07 lbs 500.00 mg exact dose Induction Dose: Yes [] No [X]	10/08/2023	30E089 CX-7527	Q 6 WEEKS	21/09/2023
	(DD/MM/YYYY)			(DD/MM/YYYY)

TDM Serum Draw Completed : Not requested

| PREMEDICATION | PRESCRIBED | ADMINISTERED | | :-- | :-- | :-- | :-- | :-- | | DOSE | ROUTE | DOSE | ROUTE | PATIENT REFUSED? |

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician: Lucia Ashby	Name of Infusion Nurse: Emeka Popov	Infusion Nurse's Signature/Date: _____ (DD/MM/YY)
---	--	---

(Remicade INFLIXIMAB logo) (Simponi IV golimumab for infusion logo) (Stelara ustekinumab logo)

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Stonebridge Health Clinic 3 (logo)

Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

REMICADE® (DIN: 02244016) Order Form Sunnymede Family Practice 4

PATIENT INFORMATION: Name: Zola Nguyen (Patient ID: S-7185261564) Preferred Name: Address: 407 Cedar Blvd, Nanaimo, ON, Canada H1L 7N8 Tel: (919) 340-3971 Date of Birth (DD/MM/YYYY): 1996 Gender: Female Allergies: NKDA Indication: Crohn's Disease Secondary Indication: Weight (KG): 59.00 Date of Wt (DD/MM/YYYY): 20/08/2023 Hospital ID:

PRESCRIBING PHYSICIAN INFORMATION: Name: Dr. Pablo Dubois Licence Number: Address: 134 Brookmere Blvd, Nanaimo, ON A6G 3K2 Tel: (795) 884-5038 Pager: Fax: (913) 639-7813 Ref: MZ-5741699168 Pharmacy Name: Viktor Weaver Fax: (698) 469-8634

PRESCRIBING PHYSICIAN SECTION

Schedule	Starting Week #	Administration	Drug	DIN	Dose	Precision	Frequency	Repeats
Maintenance		Infusion	Remicade	02244016	500 mg	Exactly	Every 6 Week(s)	

DURATION: 52 Weeks This is: ☐ first REMICADE order for this patient ☒ OR a renewal ☐ OR a change in prescription No substitutions ☒ Utilize the Recommended Standard Protocol to infuse REMICADE over no less than 2 hours or as tolerated, and manage infusion reactions as applicable ☐ If my patient has received the last three 2-hour infusions without any type of infusion reaction, initiate the following order: Utilize the Shortened Infusion Protocol to infuse REMICADE over no less than 1 hour, or as tolerated, and manage reactions as applicable. Adult patients eligible for shortened infusion: Rheumatoid Arthritis, Crohn's Disease (dose < 10 mg/kg) or Ulcerative Colitis (dose < 10 mg/kg) ☐ Other:

PRETREATMENT ORDER Option 1 ☒ No pre-medications required Option 2 ☐ Please Check desired pretreatment medication(s) administered prior to infusion at clinic (indicate dose/route) ☐ Diphenhydramine (e.g., Benadryl) _____ mg ☐ Acetaminophen _____ mg
_____ ☐ Hydrocortisone _____ mg
_____ ☐ Dimenhydrinate (e.g., Gravol) _____ mg
_____ ☐ Desloratadine _____ mg
_____ ☐ Other:

RELEVANT MEDICAL/SURGICAL HISTORY, MEDICATION(S) AND NOTES: TB Test ☐ Not required OR Date Completed: 10/04/2019 Result: Negative CXR ☐ Not required OR Date Completed: 08/04/2019 Result: Normal Hep B ☐ Not required OR Date Completed: 08/04/2019 Result: Negative

PRESCRIBER CERTIFICATION I certify that this prescription is an original prescription and will not be reused. Physician Signature: Pablo Dubois Date: Aug 20, 2023 *Effective date.

Fax order to: Cubtf Lxnyym Fax: (284) 444-1640 Alberta | New Brunswick, Ontario | N8J 5H2 |
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Ref ID : EKJ13431170542(R5)
Submitted by : eleni.ohara67@stonebridgehealthclinic.ca
Company or Vendor Name : Glenmore Specialist Centre 6

Complaint

Vendor Number	
Is this a possible Adverse Event or Special Situation?	Yes
Is this a possible Product Quality Complaint?	No
Was this complaint reported from a J&J program?	No
When was J&J first notified of this complaint?	Sep 21, 2023
Provide the narrative or additional information here	patient called in sick for her appointment this morning, developed a fever. appointment rescheduled. S-7185261564

Reporter Details

Details about the person who informed you of this complaint 1	
Select the person who informed you of this complaint	Other Health Professional
Title	
First Name	[REDACTED-REPORTER-NAME]
Last Name	[REDACTED-REPORTER-NAME]
Facility Name	Glenmore Specialist Centre 6
Address Line 1	
Address Line 2	
City	
County	
State	
Postal Code	
Country	CANADA
Telephone	
Fax	
Email Address	eleni.ohara67@stonebridgehealthclinic.ca

Details about the person who informed you of this complaint 1	
Did the reporter administer the product?	Unknown
Does J&J have permission to contact the reporter?	No
Did the reporter send this report to the FDA?	

Suspect Products

Products 1(Primary Suspect Product)	
J&J Product Name	REMICADE [Drug] [Solution for infusion]
Product purchased in	CANADA
Vaccine Anatomical Approach Site	
Was the product stored in appropriate temperature conditions? and was it properly stored from receipt to administration? If not, please explain (ex: delay in cold storage, temperature excursions, etc .)	

Date of Report [REDACTED-DATE] Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

Ref ID : EKJ13431170542(R5) Submitted by : eleni.ohara67@stonebridgehealthclinic.ca

Please Explain	
If a multidose vial, how many times, and for how long (cumulative), was the vaccine removed from storage?	
What was the formulation?	Solution for infusion
Indication	
What was the route of administration?	
What action was taken in response to the complaint?	
Was this part of the CAR-T therapy pathway (e.g. Apheresis, bridging therapy) ?	No
When did the patient take or use the product? - Start	
When did the patient take or use the product? - End	
Is the product lot number available?	Yes
Provide the lot number of the product	22L011
Provide the product expiration date	Oct 31, 2025
Is the product sample available?	No
Provide the reason why sample is not available	Discarded

Specify Other	
Number of units involved in this Complaint	
What was the dose?	
What was the strength?	
What was the frequency?	
What was the frequency time?	
Where was the product purchased?	
Contact Phone Number for where product was purchased	
Place where product was administered	
Who administered the product?	
Provide the controlled substance number (for controlled substances only)	
Provide the GTIN number	
Provide the NDC number	
Provide the UDI number	
Provide the Serial number	
EEA system alert number	
EEA system alert description	
Provide the Prescription number	
Is the complaint related to a specific part used to administer the product?	
Describe which specific part of the device or device component was involved	

Date of Report [REDACTED-DATE] Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996 Page 2 of 5

Ref ID : EKJ13431170542(R5) Submitted by : eleni.ohara67@stonebridgehealthclinic.ca

When did the problem occur?	
Did the patient experience harm from the product problem?	
Describe the harm the patient experienced from the product problem	
Were the product instructions for use followed?	
Describe why the instructions were not followed	
Who was using the device(operator of the device)	
Was single use device reprocessed and reused?	
Usage of device	

Complaint Description	fever
According to the reporter, is this complaint related to J&J product?	
Did the complaint abate after user stopped or the dose reduced?	
Did the complaint reappear after reintroduction?	

Concomitant Product(s)

Provide details if concomitant medication was used	
--	--

Complaint Description

Complaint Description 1

What is the complaint (e.g. adverse event, special situation or product quality complaint)?	fever
When did this complaint start?	
What is the outcome of the complaint?	
Provide the date the complaint was resolved	
Death	
Permanent/Significant Disability	
Life Threatening	
Congenital Anomaly/Birth Defect	
Hospitalization	
Other Serious	
Emergency room/department or Urgent care	
Doctor/healthcare professional office	
Serious Injury/Death by device	
Requires medical or surgical intervention to prevent permanent damage	
Non Serious	
Date of Death	
What was the cause of death?	
Was autopsy performed?	

Provide the results of autopsy	
Hospital admission date	
Hospital discharge date	
Number of Days	
Hospital Name	
Hospital City	
Hospital State	

Patient

Is the reporter the patient?	
Provide the patient initials	Nguyen
What is the gender/sex of the patient?	Female
Is the patient pregnant?	No
What is the expected due date?	
What is the last menstrual date?	
What is the gestational period of the patient	
What is the date of birth of the patient?	1996
What was the age of the patient at the time the complaint first occurred?	
What is the age group of the patient?	
What is the height of the patient?	
What is the weight of the patient at the time Complaint first occurred?	
Patient Race	
What is the ethnicity of the patient?	
Consent to contact the patient?	No
Did the patient take the product as directed	
Provide details why the patient did not take the product as directed	

Medical History

Provide the medical history of the patient	
Does the patient have any allergies?	

Provide details of the allergies	
Was there drug abuse or illicit drug usage?	
Provide details drug abuse or illicit drug usage	
Does the patient consume alcohol?	
Provide the details(indicate consumption per day, week, month)	
Does the patient smoke?	
Provide details of cigarettes(indicate consumption per day, week, month)	

Product History

Date of Report [REDACTED-DATE] Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

Ref ID : EKJ13431170542(R5) Submitted by : eleni.ohara67@stonebridgehealthclinic.ca

Provide details if patient has product history	
--	--

Lab Investigations

Is the patient diagnostic data available?	
---	--

Lab Test Details 1

Provide the lab test details(including Outpatient Services, ECG, Biopsy, etc.)	
Date on which the lab test was conducted	
Provide results of the lab test	

Date of Report [REDACTED-DATE] Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

S-7185261564 TG-4526896401

Highpark Health Centre 2

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient: Nguyen	First Name of Patient: Zola (Hospital ID:)	Date of birth: (DD/MM/YYYY) 1996
--	--	--

2. INFUSION CONFIRMATION REPORT

TO:	FROM:
Prescribing Physician:: Pablo Dubois	Infusion Location: Harbour Medical Centre 5
Fax #: (913) 639-7813	Contact Person: Mensah Dubois
	Fax #: (878) 540-4748
	Phone #: (878) 540-4748

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Harbour Medical Centre 5	Highpark Health Centre Coordinator Name: Cubtf Lxnyym
Phone #: 219 255 9201	Fax #: (284) 444-1640

5. INFUSION INFORMATION

Remicade Dose Given:	Date of Infusion: 27/09/2023	Lot # 83U668.S EXP: [REDACTED-DATE]	Infusion Frequency: q6weeks	Next Infusion Scheduled 02/11/2023
Weight 58.00kg /127.87 lbs	(DD/MM/YYYY)			(DD/MM/YYYY)
500.00 mg exact dose				
Induction Dose: Yes [] No [X]				

TDM Serum Draw Completed : Not requested

PREMEDICATION	PRESCRIBED	ADMINISTERED
	DOSE	ROUTE

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician: Dr. Whitmore	Name of Infusion Nurse: Mensah Dubois	Infusion Nurse's Signature/Date:
		(DD/MM/YY)

(Remicade® INFLIXIMAB) (Simponi® IV golimumab for infusion) (Stelara® ustekinumab)

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Stonebridge Health Clinic 3 (logo)

Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

S-7185261564 BD-9743483766

Highpark Health Centre 2

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO: Prescribing Physician:: Pablo Dubois Fax #: (913) 639-7813

FROM: Infusion Location: Harbour Medical Centre 5 Contact Person: Emeka Popov Fax #: (289) 988-2775
Phone #: 233-583-8176

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Harbour Medical Centre 5 Highpark Health Centre Coordinator Name: Cubtf
Lxnyym Phone #: 219 255 9201 Fax #: (284) 444-1640

5. INFUSION INFORMATION

Remicade Dose Given: Weight 59.90kg /132.06 lbs 500.00 mg exact dose Induction Dose: Yes [] No [X]

Date of Infusion: 02/11/2023 (DD/MM/YYYY)

Lot # 23C076 AL-2026

Infusion Frequency: Q 6 WEEKS

Next Infusion Scheduled 14/12/2023 (DD/MM/YYYY)

TDM Serum Draw Completed: Not requested

| PREMEDICATION | PRESCRIBED | ADMINISTERED | | :--- | :--- | :--- | :--- | :--- | | **DOSE | ROUTE |**
DOSE | ROUTE | PATIENT REFUSED? |

6. INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician: Esme Zhang

Name of Infusion Nurse: Emeka Popov

Infusion Nurse's Signature/Date:

(DD/MM/YY)

Remicade INFLIXIMAB / Simponi IV golimumab for infusion / Stelara ustekinumab

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Stonebridge Health Clinic 3

Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

ADVANCE

RENFLEXIS® (DIN: 02470373) Order Form

PATIENT INFORMATION: Name: Zola Nguyen (Patient ID: S-7185261564) Preferred Name: Address: 499 Pine St, Nanaimo, ON, Canada H1L 7N8 Tel: (919) 340-3971 Date of Birth (DD/MM/YYYY): 1996 Gender: Female Allergies: NKDA Indication: Crohn's Disease Secondary Indication: Weight (KG): 60.00 Date of Wt (DD/MM/YYYY): 15/11/2023 Hospital ID:

PRESCRIBING PHYSICIAN INFORMATION: Name: Dr. Pablo Dubois Licence Number: Address: 134 Brookmere Blvd, Nanaimo, ON A6G 3K2 Tel: (795) 884-5038 Pager: Fax: (913) 639-7813 Ref: MH-0208919752 Pharmacy Name: Viktor Weaver Fax: (698) 469-8634

PRESCRIBING PHYSICIAN SECTION

Schedule	Starting Week #	Administration	Drug	DIN	Dose	Precision	Frequency	Repeats
Maintenance		Infusion	Renflexis	02470373	500 mg	Exactly	Every 6 Week(s)	

DURATION: 52 Weeks This is: ☒ First RENFLEXIS order for this patient ☐ OR a renewal ☐ OR a change in prescription ☒ Utilize the Recommended Standard Protocol to infuse RENFLEXIS over no less than 2 hours or as tolerated, and manage infusion reactions as applicable ☐ If my patient has received the last three 2-hour infusions without any type of infusion reaction, initiate the following order: Utilize the Shortened Infusion Protocol to infuse RENFLEXIS over no less than 1 hour, or as tolerated, and manage reactions as applicable. Adult patients eligible for shortened infusion: Rheumatoid Arthritis ☐ Other:

PRETREATMENT ORDER Option 1 ☒ No pre-medications required Option 2 Please Check desired pretreatment medication(s) administered prior to infusion at clinic (indicate dose/route) ☐ Diphenhydramine (e.g. Benadryl) ____ mg _____ ☐ Acetaminophen ____ mg _____ ☐ Hydrocortisone ____ mg _____ ☐ Dimenhydrinate (e.g., Gravol) ____ mg _____ ☐ Desloratadine ____ mg _____ ☐ Other: _____

RELEVANT MEDICAL/SURGICAL HISTORY, MEDICATION(S) AND NOTES: TB Test ☐ Not required OR Date Completed: 10/04/2019 Result: Negative CXR ☐ Not required OR Date Completed: 08/04/2019 Result: Normal Hep B ☐ Not required OR Date Completed: 08/04/2019 Result: Negative

PRESCRIBER CERTIFICATION I certify that this prescription is an original prescription and will not be reused. L...V [illegible] Physician Signature: [signature] Date: 15/11/2023 *Effective date.

Fax order to: Cubtf Lxnyym Fax: (284) 444-1640

S-7185261564 DZ-6673605390

Highpark Health Centre 2

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

- Last Name of Patient: Nguyen
- First Name of Patient: Zola
- Date of birth: (DD/MM/YYYY) 1996
- (Hospital ID:)

2. INFUSION CONFIRMATION REPORT

- TO: Prescribing Physician:: Pablo Dubois
- Fax #: (913) 639-7813
- FROM:
- Infusion Location: Harbour Medical Centre 5
- Contact Person: Kenji Okafor
- Fax #: (289) 988-2775
- Phone #: 233-583-8176

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

- Dose: (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

- Name of Northview Clinic 5: Harbour Medical Centre 5
- Phone #: 219 255 9201
- Highpark Health Centre Coordinator Name: Cubtf Lxnyym
- Fax #: (284) 444-1640

5. INFUSION INFORMATION

- Renflexis Dose Given: Weight 62.20kg / 137.13 lbs, 500.00 mg exact dose
- Induction Dose: Yes [] No [X]
- Date of Infusion: 14/12/2023 (DD/MM/YYYY)
- Lot #: f2302312 exp. 2025-ma-29
- Infusion Frequency: q6weeks
- Next Infusion Scheduled: 23/01/2024 (DD/MM/YYYY)

TDM Serum Draw Completed: Yes

PREMEDICATION	PRESCRIBED DOSE	PRESCRIBED ROUTE	ADMINISTERED DOSE	ADMINISTERED ROUTE	PATIENT REFUSED?

INFUSION REACTION INFORMATION

- Was there an infusion reaction?: No
- Adverse Event Reported to Manufacturer?: Not Applicable

7. PLEASE ASK PATIENT

- Last Blood Test Performed: (DD/MM/YYYY) Unknown
- Last Referring Physician Visit: (DD/MM/YYYY) Unknown
- Next Referring Physician Visit: (DD/MM/YYYY) Unknown

8. INFUSION ADMINISTRATION

- Name of On-Call Medical Backup Physician: Dr. Dubois
- Name of Infusion Nurse: Kenji Okafor
- Infusion Nurse's Signature/Date:
(DD/MM/YY)

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Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

Stonebridge Health Clinic 3

Sunnymede Family Practice 3®	Birchwood Care Clinic Alberta New Brunswick, ON N8J 5H2 Tel: 623-478-4875 Fax: 812-628-5017	Fax
-------------------------------------	--	------------

To: 839-286-3366 **From:** Cubtf Lxnyym **Fax:** 839-286-3366 **Date:** [REDACTED-DATE] **Subject:** Please show to Dr. Dubois

Hi Dr. Dubois,

Please see AE for Zola Nguyen who developed a psoriasis like rash, as per her description, one week after her initial Renflexis.

Is being treated with cortisone but has a second dose on Jan 24th.

Many thanks,

Cubtf Lxnyym RN, BN

Sunnymede Family Practice 4 Coordinator™, IBD

Stonebridge Health Clinic 4

Ph: (662) 733-3507 Fax: 812-628-5017

gina.poirier61@cedarspecialistgroup.ca

Office Hours: [REDACTED-DATE] - Friday 8:30am - 4:30pm

*Please be sure to advise me of any changes to your address, phone number, email, and insurance as they occur - thank you!

Confidentiality Warning: This message is intended only for the use of the individual or entity to which it is addressed, and may contain information which is privileged, confidential, proprietary or exempt from disclosure under applicable law. If you are not the intended recipient or the person

responsible for delivering the message to the intended recipient, you are strictly prohibited from disclosing, distributing, copying or in any way using this message. If you have received this communication in error, please notify the sender, and destroy and delete any copies you may have received.

Sunnymede Family Practice 5

Thank you for reporting the adverse event.

Thank you for reporting your/this adverse events(s) with our product. This information will help us maintain complete product safety information and enable us to fulfill our reporting responsibilities to Health Authorities (Regulatory Agencies), who require that we provide information on reported Adverse Event. All information concerning this report as well as follow-up queries for additional medical details will be in compliance with pertinent data privacy rules.

Your report reference ID is RLE-EE-9830-203474 Case version number is 0 Program ID is RRXBWZLMKT WWLXNGQLS JLDNEBG MZF959 Report Type is Patient Support Program/PSP Reported on 18 Jan 2024 17:37:04

Update your report

If you want to update any part of your report, please contact and refer to the Report Reference ID above.

ravi.wozniak74@maplehealthclinic.ca Find out more

You can contact Sunnymede Family Practice 5 , if you have any queries.

Product The products What is the name of the Organon product you want to report? RENFLEXIS (Infliximab)

About this product In what context was this product taken? Program product Was this product reported as having caused the adverse event(s)? Yes, it was reported that this product caused the adverse event(s).

When and why the product was taken When did the patient start taking the product? Start Date = Dec 14, 2023 What was the indication? Crohn's Disease

How the product was taken Which formulation of the product were they taking? Injection, Powder for Solution What was the route of administration? Intravenous Infusion What dose were they taking? 500 mg (milligram) Other Dosage [e.g. 24/26 mg, 1.6x10⁸ CAR-positive viable T cells or other] What was the frequency? every 6 wks What action was taken as a result of the adverse event? Unknown

Additional information

Lot or Batch number Is this a Product Quality Complaint? No

Adverse Event

The adverse events

What is the name of adverse event you want to report? rash one week after infusion

About the adverse event

What was the outcome of the adverse event? Unknown

Additional information

What was the duration for which adverse event was experienced? Start Date = Dec 21, 2023

Seriousness

Was the adverse event serious? No, it was not serious How serious was the adverse event? Description of Adverse Event(s) and/or Product Quality Complaint pt said she developed a flakey swollen irritated rash on her upper legs and "intimate area, the crease from the legs in groin and to the labia majora". She tried an

"antifungal" and then corn starch baby powder and ice packs but then went to walk in clinic after 2 weeks and was given Cortisone 0.1% to be taken 3-4 times daily for 4 wks. Area has improved quite a bit after 1 week treatment but she has been wearing loose clothing since it started.

Patient

About the patient

What is the gender of the patient? Female Was or is the patient pregnant? No

Patient details

How old were they at the time of the adverse event? 27 Years What are the initials of the patient? Nguyen What is the Patient Id# ? S-7185261564 What was their height? What was their weight? 62 kgs What is their date of birth? 1996

Patient background

What is the pertinent medical history specific to the adverse event? pt has only had one dose Renflexis since non medical switch from Remicade Please enter any additional information provided about the patient, e.g. a Organon patient support program, Organon-sponsored study etc. Please upload source documents?

Reporter

About the adverse event

In what country is the person located who reported this adverse event to you? CANADA When was the adverse event reported to you? Jan 18, 2024 Company Reference Number (For Organon Use Only) External Reference Number (For Organon Use Only)

About your company What is the name of your company? Sunnymede Family Practice 4 First name of contact person: [REDACTED-CONTACT-PERSON-NAME] Last name of contact person: [REDACTED-CONTACT-PERSON-NAME] Office phone number Email address: gina.poirier61@cedarspecialistgroup.ca Country of the company (where the contact person is located): CANADA

About the person who reported the event to you Who reported this adverse event to you? A health care practitioner Can we contact the health care practitioner if we need more information? No, don't contact them Profession:

S-7185261564 NT-5596188770

Crestwood Medical Group 3® Stonebridge Health Clinic 3

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

- **Last Name of Patient:** Nguyen
- **First Name of Patient:** Zola
- **Date of birth: (DD/MM/YYYY):** 1996
- **(Hospital ID:):**

2. INFUSION CONFIRMATION REPORT

TO:	FROM:
Prescribing Physician:: Pablo Dubois	Infusion Location: Harbour Medical Centre 5
Fax #: (913) 639-7813	Contact Person: Nadia Blackwood
	Fax #: 474 465 1025
	Phone #: 219 255 9201

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

- **Dose:** (blank) (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

- **Name of Northview Clinic 5:** Harbour Medical Centre 5
- **Phone #: 219 255 9201**
- **Highpark Health Centre Coordinator Name:** Cubtf Lxnyym
- **Fax #: (284) 444-1640**

5. INFUSION INFORMATION

- **Renflexis Dose Given:** Weight 61.00kg / 134.48 lbs 500.00 mg exact dose
- **Induction Dose:** Yes [] No [X]
- **Date of Infusion:** 23/01/2024 (DD/MM/YYYY)
- **Lot #:** F2227908 exp. 2025-06-13
- **Infusion Frequency:** Q6W
- **Next Infusion Scheduled:** 05/03/2024 (DD/MM/YYYY)
- **TDM Serum Draw Completed:** Not requested

| PREMEDICATION | PRESCRIBED | ADMINISTERED | | :--- | :--- | :--- | :--- | :--- | | DOSE | ROUTE |
DOSE | ROUTE | PATIENT REFUSED? |

INFUSION REACTION INFORMATION

- Was there an infusion reaction?: No
- Adverse Event Reported to Manufacturer?: Not Applicable

7. PLEASE ASK PATIENT

- Last Blood Test Performed: (DD/MM/YYYY): Unknown
- Last Referring Physician Visit: (DD/MM/YYYY): Unknown
- Next Referring Physician Visit: (DD/MM/YYYY): Unknown

8. INFUSION ADMINISTRATION

- Name of On-Call Medical Backup Physician: Dr. Ahmadi
- Name of Infusion Nurse: Nadia Blackwood
- Infusion Nurse's Signature/Date: (blank) (DD/MM/YY)

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Alberta | New Brunswick, ON Page 1 of 1 w.Stonebridge Health Clinic 3.com/canada Stonebridge Health
Clinic 3 Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

Riverside Medical Centre Riverside Medical Centre 4

OUTPATIENT CONSULT REQUEST from Glenmore Specialist Centre

Date: 03/03/2024

Outpatient Clinic or Appointment to be booked: Dr. Chen, GI specialist (226) 541-2662

Patient: Nguyen, Zola 579 Harlow Blvd Nanaimo, ON H1L 7N8

DOB: 1996 Health Card: 4443501074-LA Family Physician: Caldwell, Niamh Phone Number: (660) 834-9239

Known case of Crohn disease to date emergency Abdo pain, resolved no diarrhea no blood in stool

Referring physician (print name): Zamora, Hamid

Marco Volkov

[X] Please fax all imaging studies and bloodwork from today's visit

CQA-9054 Nov 14, 2021

[barcode] IR.OCRED

115 Sherwood Blvd | Nanaimo ON | T8X 0V9 | 434.594.9865 www.westbrookmedicalassociates.ca

Harbour Medical Centre 6

115 Sherwood Blvd Nanaimo, ON T8X 0V9 Phone: (237) 294-9180 Fax: (251) 680-8660

Emergency Department Report

Patient: **Nguyen, Zola** DOB/Age/Sex: 1996 / 27 / F HCN: 4443501074-LA Address: 579 Harlow Blvd Nanaimo, ON H1L 7N8 Phone Number: (660) 834-9239

HYW: A623421908 Cubt: FL8599481/55 Visit Date: 02/03/2024 Report Number: 4867-66506 Patient Location: Beckett Patient Rm/Bed:

Primary Care Provider: Niamh Caldwell Copies To: Niamh Caldwell

Physician Initial Assessment (PIA) Time Time Seen by Provider: [REDACTED-DATE]

Assessment Clinical Query abdo pain started this am increased over time hx chronos nausea diahhrea this am

aving lower abdo pain radiates to upper mid abdo, woke up with pain, worse since 13:55, has subsided now nauseous, denies vomiting, had diarrhea this morning, denies fevers, menses is due in next 1-2 days, no chance of pregnancy, decreased intake today, drinking fluids well alert and oriented x3 speaking full sentences, denies and urinary issues history of above. Patient is a known case of Crohn's disease on Remicade.

Being followed by Dr. Chen, on Remicade.

Will be getting her next Remicade coming Wednesday.

Initially the patient or Abdo pain has resolved she has a no blood in stool no vomiting no fever.

On examination patient looks well Abdo soft nontender

She does not want any pain medication at this time but I am giving her a prescription trial #3 1-2 p.o. every 4. 20 tablet prescription just in case.

She is feeling very comfortable going home. I told her if fever temperature blood in stool not feeling comfortable back to emerge. I will be sending a note to Dr. Maya Chen.

Fax: **Additional copy**

Page: 1 of 3

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Xzrxptv #: SF2571363/61 Report Number: 4867-66506

Vital Signs - Last Documented

Pulse Rate	65	02/03/2024
13:55		
Respiratory Rate	18	02/03/2024
13:55		
O2 Sat by Oximetry	100	02/03/2024
13:55		
Blood Pressure [Right]	120/83	02/03/2024
13:55		

Discharge Plan

Discharge Most Responsible Diagnosis: Crohn disease Abdo pain resolved

Interventions: ED Discharge Assessment Last Done: [REDACTED-DATE]

Disposition (Nurse Responsibility): Home (Private) No Support

Discharge Date/Time: [REDACTED-DATE]

Report Status: Signed Dictated By: Zamora, Hamid MD

<Electronically signed by Hamid Zamora>

Fax:

Additional copy

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Zasgxcx #: RFP994250/84 Report Number: 4867-66506

Dictated Date/Time: [REDACTED-DATE] Transcribed Date/Time: [REDACTED-DATE]

Fax: Additional copy

Page: 3 of 3

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Highpark Health Centre 2

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola	1996
	(Hospital ID:)	

2. INFUSION CONFIRMATION REPORT

TO:	FROM:
Prescribing Physician:: Pablo Dubois	Infusion Location: Harbour Medical Centre 5
Fax #: (913) 639-7813	Contact Person: Kenji Okafor
	Fax #: (289) 988-2775
	Phone #: 233-583-8176

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Harbour Medical Centre 5	Highpark Health Centre Coordinator Name: Cubtf Lxnyym
Phone #: 219 255 9201	Fax #: (284) 444-1640

5. INFUSION INFORMATION

	Date of Infusion:	Lot #	Infusion Frequency:	Next Infusion Scheduled
Renflexis Dose Given:	05/03/2024	u7013980 exp.	q6weeks	16/04/2024
Weight 59.90kg / 132.06 lbs	(DD/MM/YYYY)	[REDACTED-DATE]		(DD/MM/YYYY)
500.00 mg exact dose				

	Date of Infusion:	Lot #	Infusion Frequency:	Next Infusion Scheduled
Induction Dose: Yes [] No [X]				

TDM Serum Draw Completed : Not requested

PREMEDICATION	PRESCRIBED	ADMINISTERED
	DOSE	ROUTE

INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician:	Name of Infusion Nurse:	Infusion Nurse's Signature/Date:
Dr. Dubois	Kenji Okafor	

		(DD/MM/YY)

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(Remicade INFLIXIMAB) (Simponi IV golimumab for infusion) (Stelara ustekinumab) | Northview Clinic 7 Alberta | New Brunswick, ON | www.brookfieldmedicalcentrenorth.ca | Stonebridge Health Clinic 3 (logo)
Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

Fax Number: 663-964-2399 Recipient: Dubois, Pablo

Birchwood Care Clinic 5 Radiology Tel: (496) 839-2065 MRI Appointment Notification

****As of June 2016, MRI EXAMINATIONS WILL BE BOOKED 24 HOURS/DAY**** Please ensure patients are aware appointments can be booked during midnight hours. The appointment times below are state in military time (using the 24 hour clock). Please ensure all patients clearly understand whether their appointment is booked in the AM or PM.

Dubois, Pablo Fax: (913) 639-7813 Nanaimo

The following patient have had appointments **Booked** in Community-Wide Scheduling between The following patient have had appointments booked in Community-Wide Scheduling between [REDACTED-DATE] **AND** [REDACTED-DATE]

Patient	HCN	Scheduled For
Nguyen, Zola	2893386601-KJ	28 May 2024 15:15
Appointment: MRI Abdomen 4 REP wGD 3D 30		Appointment Status: Booked

All patients must arrive 45 minutes prior to appointment For registration and screening

Contact your patient with date and time of appointment **IMMEDIATELY** to minimize patient inquiries and No Shows

Patient Preparation For environmental reasons, General Medicine has stopped issuing plastic bags. We ask that you request patients bring their own reusable bag to hold their garments during their exam.

If your patient is claustrophobic, the physician is responsible for providing the patient with sedation and making the patient aware that they must bring a driver with them. We advise that the patient takes the sedation prior to arrival to ensure the patient is sedated for appointment.

Your patient will receive a phone confirmation approximately 1 week prior to their scheduled appointment

**** END OF REPORT ****

S-7185261564 C-8625994250

Highpark Health Centre 2

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola	1996
	(Hospital ID:)	

2. INFUSION CONFIRMATION REPORT

TO:	FROM:
Prescribing Physician:: Pablo Dubois	Infusion Location: Harbour Medical Centre 5
Fax #: (913) 639-7813	Contact Person: Paftgr Aacanx
	Fax #: (289) 988-2775
	Phone #: 233-583-8176

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Harbour Medical Centre 5	Highpark Health Centre Coordinator Name: Cubtf Lxnyym
Phone #: 219 255 9201	Fax #: (284) 444-1640

5. INFUSION INFORMATION

Renflexis Dose Given:	Date of Infusion: 16/04/2024	Lot # DFH64202 WY- 9181 exp. [REDACTED-DATE]	Infusion Frequency: q6weeks	Next Infusion Scheduled 28/05/2024
Weight 59.00kg /130.07 lbs				
500.00 mg exact dose	(DD/MM/YYYY)			(DD/MM/YYYY)

Renflexis Dose Given:	Date of Infusion: 16/04/2024	Lot # DFH64202 WY- 9181 exp. [REDACTED-DATE]	Infusion Frequency: q6weeks	Next Infusion Scheduled 28/05/2024
Induction Dose: Yes [] No [X]				

TDM Serum Draw Completed : Not requested

PREMEDICATION	PRESCRIBED	ADMINISTERED
	DOSE	ROUTE

INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician: Bw. Hjbufw	Name of Infusion Nurse: Paftgr Aac anx	Infusion Nurse's Signature/Date:

		(DD/MM/YY)

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Remicade INFLIXIMAB / Simponi IV golimumab for infusion / Stelara ustekinumab

Northview Clinic 7 Alberta | New Brunswick, ON www.northviewclinicnorth.ca

Stonebridge Health Clinic 3

Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

Harbour Medical Centre 7

Prescription Refill Reauthorization Request

Riverside Medical Centre 3#: Brookfield Medical Centre 6 313 Glenarm Blvd Nanaimo, ON Y0H 6P1
CANADA Phone: (283) 952-6505 Fax: (781) 731-2825

Pharmacist Information Name: Emeka Popov Helena Ingram

Printed: 2024-05-20

Patient: Nguyen, Zola	PHN: 7123642028	BirthDate: 1996
Address: 579 Harlow Blvd		Phone: 996-980-7696

Medication	Last Fill	Directions	Reauthorization
LORAZEPAM SUBLINGUAL 1MG LORAZEPAM 1MG SL Qty: 2 TAB Days Supply: 1	2022-09-16 Days Since: 612 Rx: 3810609 Tx: 05404912	PLACE 1 TABLET UNDER THE TONGUE 30 MINUTES PRIOR TO MRI AND TAKE 2ND TABLET WHEN NEEDED	Approved: [] Additional Refills: []

Notes:

Prescriber: Dr. Pablo Dubois Ximena Cardenas Phone: 294-913-5337 Address: 427 Glenarm Rd Fax: 219-422-8170

(blank)	(blank)
Prescriber Signature	Date

Please fax completed form to: (781) 731-2825

This telecopy is confidential and is intended to be received by the addressee only. If the reader is not the intended recipient thereof you are advised that any dissemination, distribution or copying of this facsimile is strictly prohibited. Each prescription represents the original of the prescription drug order. The pharmacy addressee noted above is the only intended recipient and there are not others. The original prescription have been invalidated and securely filed and will not be transmitted elsewhere at another time.

S-7185261564 QS-2095300211

Crestwood Medical Group 3® Stonebridge Health Clinic 3

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO: Prescribing Physician:: Pablo Dubois Fax #: (913) 639-7813

FROM: Infusion Location: Harbour Medical Centre 5 Contact Person: Paftgr Aacanx Fax #: (289) 988-2775
Phone #: 233-583-8176

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Harbour Medical Centre 5 Phone #: 960-886-6599

Highpark Health Centre Coordinator Name: Cubtf Lxnyym Fax #: (284) 444-1640

5. INFUSION INFORMATION

Renflexis Dose Given: Weight 60.00kg / 132.28 lbs 500.00 mg exact dose Induction Dose: Yes [] No [X]

Date of Infusion: 28/05/2024 (DD/MM/YYYY)

Lot # x9786308 exp. [REDACTED-DATE]

Infusion Frequency: q6weeks

Next Infusion Scheduled 09/07/2024 (DD/MM/YYYY)

TDM Serum Draw Completed : Yes

| PREMEDICATION | PRESCRIBED | ADMINISTERED | | :--- | :--- | :--- | :--- | :--- | | DOSE | ROUTE |
DOSE | ROUTE | PATIENT REFUSED? |

INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician: Dr. Dubois Name of Infusion Nurse: Paftgr Aacanx

Infusion Nurse's Signature/Date:

(DD/MM/YY)

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(Remicade® INFLIXIMAB) (Simponi® IV golimumab for infusion) (Stelara® ustekinumab)

Northview Clinic 7 Alberta | New Brunswick, ON | www.harbourmedicalcentresouth.ca

Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

Stonebridge Health Clinic 3

Northview Clinic 8
78 Fcuc Rcffar
New Brunswick, Ontario
J5U6Z6
(434) 922-2032
(434) 922-2032

Documentation for Zola Nguyen
Gender: F Date of Birth: 1996 Age: 28

-[Feb 22, 2024 :]

Junaid Verma*****

Diagnosis:
1 - TNF induced psoriasis

Management Plan
Diagnosis 1
TNF induced psoriasis
Discussed pathophysiology of this disease
Will try to control with topicals, especially since her IBD is well controlled on IFX
Zoryve cream qHS

[Signed on 22-Feb-2024 10:28 by Junaid Verma]

Created by: OSCAR The open-source EMR www.harbourmedicalcentrewest.ca 2024-06-17

S-7185261564 XP-7762257136

Highpark Health Centre 2

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO: Prescribing Physician:: Pablo Dubois Fax #: (913) 639-7813

FROM: Infusion Location: Harbour Medical Centre 5 Contact Person: Paftgr Aacanx Fax #: (289) 988-2775
Phone #: 233-583-8176

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Harbour Medical Centre 5 Phone #: 960-886-6599 Highpark Health Centre
Coordinator Name: Cubtf Lxnyym Fax #: (284) 444-1640

5. INFUSION INFORMATION

Renflexis Dose Given: Weight 61.00kg /134.48 lbs 500.00 mg exact dose Induction Dose: Yes [] No [X]

Date of Infusion: 09/07/2024 (DD/MM/YYYY)

Lot # z0628186 exp. [REDACTED-DATE]

Infusion Frequency: q6weeks

Next Infusion Scheduled 20/08/2024 (DD/MM/YYYY)

TDM Serum Draw Completed : Yes

PREMEDICATION	PRESCRIBED	ADMINISTERED
	DOSE	ROUTE

INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY) Unknown	Next Referring Physician Visit: (DD/MM/YYYY) Unknown
09/07/2024		

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician: Bw. Hjbufw Name of Infusion Nurse: Paftgr Aacanx Infusion Nurse's Signature/Date: _____ (DD/MM/YY)

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Remicade® INFLIXIMAB | Simponi® IV golimumab for infusion | Stelara® ustekinumab

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Stonebridge Health Clinic 3

Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

Dr. Emeka Popov 449 Kestrel Rd 449 Kestrel Rd Nanaimo, Ontario A6G 3K2 461-726-4419

Jul 23, 2024

Dr. Pablo Dubois 479 Juniper St 623 River Rd Nanaimo, ON Phone: 294-913-5337 Fax: 219-422-8170

Dear Dr. Pablo Dubois:

Re: Zola Nguyen Mar 16, 1996 Age: 28 yr HN: 3421 908 070 TF 996-980-7696 (H)

Thank referring this pleasant 28-year-old female for possible surgical resection of her fibrostenotic segment on the background of Crohn's disease

Her past medical history is significant for Crohn's disease

Medications include iron supplements, Renflexis for Crohn's disease started in [REDACTED-DATE]

Surgical history significant for previous cholecystectomy done laparoscopically in 2016

History of present illness: This pleasant 28-year-old woman has had irregular bowel movements nonbloody, she denies any nausea vomiting but experiences significant bloating. She has a lot of food avoidances as well.

She certainly is exhibiting some obstructive symptoms.

On examination her abdomen is soft nontender nondistended no mass lesions are palpated.

Imaging was reviewed and demonstrates distal ilial fibrostenotic segment.

Assessment plan: We discussed possible ileocolic resection today as well as the role of surgery in patients with Crohn's disease. The risks of the procedure including infection, bleeding, anastomotic dehiscence as well as perioperative risks were all discussed.

Will be consented today for laparoscopic possible open ileocolic resection. Consents were signed. Will make arrangements to do this in the near future.

Yours truly,

[image]

Dr. Emeka Popov

S-7185261564 NX-0833072894

Crestwood Medical Group

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION | Last Name of Patient: | First Name of Patient: | Date of birth:
(DD/MM/YYYY) | | :-- | :-- | :-- | | Nguyen | Zola (Hospital ID:) | 1996 |
2. INFUSION CONFIRMATION REPORT TO: Prescribing Physician:: Pablo Dubois Fax #: (913) 639-7813

FROM: Infusion Location: Harbour Medical Centre 5 Contact Person: Paftgr Aacanx Fax #: (289) 988-2775
Phone #: 233-583-8176

3. IMMUNOSUPPRESSANTS (IF APPLICABLE) Dose:
_____ (mg, Frequency, and Route)
4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION Name of Northview Clinic 5:
Harbour Medical Centre 5 Phone #: 960-886-6599 Highpark Health Centre Coordinator Name: Cubtf
Lxnyym Fax #: (284) 444-1640
5. INFUSION INFORMATION Renflexis Dose Given: Weight 60.00kg / 132.28 lbs 500.00 mg exact
dose Induction Dose: Yes [] No [X]

Date of Infusion: 20/08/2024 (DD/MM/YYYY)

Lot # f2302329 exp. 2027-fe-17

Infusion Frequency: q6weeks

Next Infusion Scheduled 01/10/2024 (DD/MM/YYYY)

TDM Serum Draw Completed : Not requested

PREMEDICATION | PRESCRIBED | ADMINISTERED | | :-- | :-- | :-- | :-- | :-- | | DOSE | ROUTE | DOSE
| ROUTE | PATIENT REFUSED? |

INFUSION REACTION INFORMATION Was there an infusion reaction? : No Adverse Event Reported to
Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT Last Blood Test Performed: (DD/MM/YYYY) Unknown Last Referring
Physician Visit: (DD/MM/YYYY) Unknown Next Referring Physician Visit: (DD/MM/YYYY) Unknown
8. INFUSION ADMINISTRATION Name of On-Call Medical Backup Physician: Dr. Dubois Name of
Infusion Nurse: Paftgr Aacanx Infusion Nurse's Signature/Date:
_____ (DD/MM/YY)

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S-7185261564 C-8625994250

Crestwood Medical Group

Post-infusion Feedback Report

(For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO: Primary Health Care Professional: Pablo Dubois Fax #: (913) 639-7813

FROM: Infusion Location: Harbour Medical Centre 5 Contact Person: Dalia Watanabe Fax #: (289) 988-2775 Phone #: 233-583-8176

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Harbour Medical Centre 5 Phone #: 960-886-6599 Highpark Health Centre
Coordinator Name: Cubtf Lxnyym Fax #: (284) 444-1640

5. INFUSION INFORMATION

Renflexis Dose Given: Weight 60.20kg / 132.72 lbs 500.00 mg exact dose Induction Dose: Yes [] No [X]

Date of Infusion:	Lot #	Infusion Frequency:	Next Infusion Scheduled
01/10/2024	P8477334	Q6weeks	12/11/2024
(DD/MM/YYYY)	[REDACTED-DATE]		(DD/MM/YYYY)

TDM Serum Draw Completed: Not requested

PREMEDICATION	PRESCRIBED	ADMINISTERED
	DOSE	ROUTE

INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician:	Name of Infusion Nurse:	Infusion Nurse's Signature/Date:
Dr. Ahmadi	Dalia Watanabe	_____
		(DD/MM/YYYY)

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Alberta | New Brunswick, ON | N8J 5H2 | www.lakeshorespecialtycliniceast.ca Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

RENFLEXIS® (DIN: 02470373) Order Form

Highpark Health Centre

PATIENT INFORMATION:

- Name: Zola Nguyen (Patient ID: S-7185261564)
- Preferred Name:
- Address: 499 Pine St, Nanaimo, ON, Canada H1L 7N8
- Tel: (919) 340-3971
- Date of Birth (DD/MM/YYYY): 1996
- Gender: Female
- Allergies: NKDA
- Indication: Crohn's Disease
- Secondary Indication:
- Weight (KG): 60.00 Date of Wt (DD/MM/YYYY): 15/11/2023
- Hospital ID:

PRESCRIBING PHYSICIAN INFORMATION:

- Name: Dr. Pablo Dubois
- Licence Number:
- Address: 134 Brookmere Blvd, Nanaimo, ON A6G 3K2
- Tel: (795) 884-5038
- Pager:
- Fax: (913) 639-7813
- Ref: PM-5340812870
- Pharmacy Name: Viktor Weaver
- Fax: (698) 469-8634

PRESCRIBING PHYSICIAN SECTION

Schedule	Starting Week #	Administration	Drug	DIN	Dose	Precision	Frequency	Repeats
Maintenance		Infusion	Renflexis	02470373	500 mg	Exactly	Every 6 Week(s)	

DURATION: 52 Weeks

This is: ☐ first RENFLEXIS order for this patient ☒ OR a renewal ☐ OR a change in prescription

☒ Utilize the Recommended Standard Protocol to infuse RENFLEXIS over no less than 2 hours or as tolerated, and manage infusion reactions as applicable ☐ If my patient has received the last three 2-hour infusions without any type of infusion reaction, initiate the following order: Utilize the Shortened Infusion Protocol to infuse RENFLEXIS over no less than 1 hour, or as tolerated, and manage reactions as applicable. Adult patients eligible for shortened infusion: Rheumatoid Arthritis ☐ Other:

PRETREATMENT ORDER Option 1 ☒ No pre-medications required Option 2 ☐ Please Check desired pretreatment medication(s) administered prior to infusion at clinic (indicate dose/route)

- ☐ Diphenhydramine (e.g. Benadryl) _____ mg _____
- ☐ Acetaminophen _____ mg _____
- ☐ Hydrocortisone _____ mg _____
- ☐ Dimenhydrinate (e.g., Gravol) _____ mg _____
- ☐ Desloratadine _____ mg _____
- ☐ Other: _____

RELEVANT MEDICAL/SURGICAL HISTORY, MEDICATION(S) AND NOTES:

- TB Test ☐ Not required OR Date Completed: 10/04/2019 Result: Negative
- CXR ☐ Not required OR Date Completed: 08/04/2019 Result: Normal
- Hep B ☐ Not required OR Date Completed: 08/04/2019 Result: Negative

PRESCRIBER CERTIFICATION I certify that this prescription is an original prescription and will not be reused.

Physician Signature: [signature: Pablo Dubois] Date: Oct 11, 2024 *Effective date LU 546

Fax order for Cubtfx Lxnyym Fax: (284) 444-1640

S-7185261564 LA-4912499131

Stonebridge Health Clinic 3 Crestwood Medical Group 4®

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO: Primary Health Care Professional: Pablo Dubois Fax #: (913) 639-7813

FROM: Infusion Location: Harbour Medical Centre 5 Contact Person: Nadia Blackwood Fax #: 474 465 1025 Phone #: 219 255 9201

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Harbour Medical Centre 5 Phone #: 892 531 6328 Highpark Health Centre
Coordinator Name: Cubtf Lxnyym Fax #: (284) 444-1640

5. INFUSION INFORMATION

Renflexis Dose Given: Weight 60.70kg /133.82 lbs 500.00 mg exact dose Induction Dose: Yes [] No [X]

Date of Infusion: 12/11/2024 (DD/MM/YYYY)

Lot # A8434390 exp. 2027-04-11

Infusion Frequency: Q6W

Next Infusion Scheduled 18/12/2024 (DD/MM/YYYY)

TDM Serum Draw Completed : Yes

| PREMEDICATION | PRESCRIBED | ADMINISTERED | | :--- | :--- | :--- | :--- | :--- | | DOSE | ROUTE |
DOSE | ROUTE | PATIENT REFUSED? |

INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician:	Name of Infusion Nurse:	Infusion Nurse's Signature/Date:
Dr. Dubois Purolator PIN # 057758477334	Nadia Blackwood	 (DD/MM/YY)

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Alberta | New Brunswick, ON | N8J 5H2 | www.northviewclinicnorth.ca

Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

Dr. Emeka Popov British Columbia British Columbia Nanaimo, Ontario A6G 3K2 461-726-4419

Dec 21, 2024

Dr. Pablo Dubois 479 Juniper St British Columbia Nanaimo, ON Phone: 294-913-5337 Fax: 219-422-8170

Dear Dr. Pablo Dubois:

Re: Zola Nguyen Mar 16, 1996 Age: 28 yr HN: 4773 344 435 BE 996-980-7696 (H)

I did a telephone follow-up with this pleasant female today she is doing very well post laparoscopic ileocolic resection for Crohn's disease her bowel function and energy appetite are all improving steadily. Pathology was consistent with Crohn's disease.

She has no further concerns her incisions are healing well.

Yours truly,

Dr. Emeka Popov

Nguyen, Zola Birth date 1996 #27908 Page 1/1

Dec 21, 2024 Letter BS

Needs Printing

To: Dr. Pablo Dubois Phone: 294-913-5337 Fax: 219-422-8170 Dear Dr. Pablo Dubois:

Re: Zola Nguyen Mar 16, 1996 Age: 28 yr HN: 4773 344 435 BE 996-980-7696 (H)

I did a telephone follow-up with this pleasant female today she is doing very well post laparoscopic ileocolic resection for Crohn's disease her bowel function and energy appetite are all improving steadily. Pathology was consistent with Crohn's disease.

She has no further concerns her incisions are healing well.

PS Suite® EMR report Printed by kn on Dec 29, 2024 19:28 This document contains personal identifiable information that must be treated confidentially. Any unauthorized use or disclosure is prohibited.

S-7185261564 RQ-7466567185

Crestwood Medical Group Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO: Primary Health Care Professional: Pablo Dubois Fax #: (913) 639-7813

FROM: Infusion Location: Harbour Medical Centre 5 Contact Person: Liam Takahashi Fax #: Liam Takahashi Phone #: (964) 258-3788

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: Remicade, q4w, IV (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Harbour Medical Centre 5 Phone #: 892 531 6328 Highpark Health Centre Coordinator Name: Cubtf Lxnyym Fax #: (284) 444-1640

5. INFUSION INFORMATION

Renflexis Dose Given: Weight 59.00kg /130.07 lbs 500.00 mg exact dose Induction Dose: Yes [] No [X]

Date of Infusion: 18/12/2024 (DD/MM/YYYY)

Lot # vgy49977 hw 1060 x 5

Infusion Frequency: q6w

Next Infusion Scheduled 29/01/2025 (DD/MM/YYYY)

TDM Serum Draw Completed : Not requested

PREMEDICATION	PRESCRIBED	ADMINISTERED
	DOSE	ROUTE

INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician:	Name of Infusion Nurse:	Infusion Nurse's Signature/Date:
Dr. Ashby	Liam Takahashi	 (DD/MM/YY)

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Highpark Health Centre 4 Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

Nguyen, Zola DOB: 1996 (28y) Female HCN: 7123642028 ConnectingOntario ClinicalViewer

Operative Report - 20 Nov 2024 21:52 (Riverside Medical Centre 4) Provider: Popov, Emeka Status: Final

Operative Report

Riverside Medical Centre 4

115 Sherwood Blvd Nanaimo, ON T8X 0V9 Phone: (760) 781-3742 Fax: (760) 781-3742

Operative Report

Patient: Nguyen, Zola DOB/Age/Sex: 1996 / 28 / F HCN: 2893386601-KJ Address: 579 Harlow Blvd
Nanaimo, ON H1L 7N8 Phone Number: (760) 781-3742

HYW: A623421908 Fffg: TY0845192/89 Visit Date: Report Number: 3547-06708 Patient Location: Morris
Patient Rm/Bed: Morris

Attending Provider: Boyd, Kira Primary Care Provider (Family Provider): Richardson, Caleb Copies To:
Richardson, Caleb; Boyd, Kira

Operative Report Operative Details

Operation Date: [REDACTED-DATE] Actual Procedures p Laparoscopic Possible Open Ileocolic
Resection(Not Applicable) - Kira Boyd

Anesthesia Type General

Case Staff Anesthesiologist: Dr. Zhang Surgical Assist: Nowak, Nina

Surgeon: Emeka Popov

Details of Procedure Preoperative diagnosis -ileocolic Crohn's disease

Postoperative diagnosis same

Procedure: Laparoscopic ileocolic resection

Operative note: This pleasant patient was brought to the operating room under general anesthesia prepped
and draped appropriately in the supine position with the left arm tucked in.

Preoperative checklist and consent was obtained. Risks of the procedure including infection,

Page No: 1

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Dubois Date: 03 Feb 2025 08:34

bleeding, conversion to open as well as risk of injuries to adjacent tissues were discussed in great detail.

We started by making a supraumbilical skin incision using a 11 blade scalpel dissection carried through subcutaneous tissue into the abdominal cavity and direct visualization. Two #1 Vicryl sutures were placed for stay sutures and a 10 mm Hassan trocar was placed.

We then inserted 2 additional ports a suprapubic port as well as a left lower quadrant port.

An additional 5 mm subxiphoid port was also placed.

The 10 mm laparoscope was inserted and the right colon was visualized.

I started by the mobilization from above getting into the lesser sac and mobilizing the hepatic flexure the duodenum was swept retroperitoneally and I took down the lateral attachments all the way down to the appendix I then turned my attention to doing the inferior dissection by mobilizing the small bowel along the mesenteric edge keeping the right ureter in view and away from the dissection field. I then continued this dissection superiorly and once adequate mobility was obtained I made a small incision in the midline approximately 2 to 3 cm in size and placed a wound protector

I then exteriorized the specimen and divided the proximal distal bowel using the GIA 80 stapler. I then lined up the bowel in a isoperistaltic manner created 2 enterotomies away from the suture line and passed a GIA 80 stapler through this. I closed the defect using two 3-0 Vicryl sutures in a 2 layer fashion imbricating the first suture line with the second. 2 crotch sutures were placed using a 2-0 Vicryl suture.

The anastomosis was well vascularized and under no tension whatsoever.

The fascia was closed using #1 Vicryl sutures.

All skin incisions were closed using 3-0 Monocryl sutures.

Steri-Strips and dressings were applied.

Patient was extubated and taken to recovery in stable condition. No immediate complications were noted, estimated blood loss was minimal. All sponge and instrument counts were correct at the end of the case.

Report Status: Signed Dictated By: Boyd, Kira

Page No: 2 Privacy Disclaimer: This information is confidential and may only be used by the patient or individual listed in the footer. If found, please return to the organization listed in the footer. Shred when no longer needed. Generated from ConnectingOntario User Id: cf-FA 6fvzwX LKMAkvJycZ6R7jrANH- Organization: Dr. Pablo Dubois Date: 03 Feb 2025 08:34

Dictated Date/Time: [REDACTED-DATE] Transcribed Date/Time: [REDACTED-DATE]

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S-7185261564 ZA-6281862599

Crestwood Medical Group Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION | Last Name of Patient: | First Name of Patient: | Date of birth:
(DD/MM/YYYY) | | :-- | :-- | :-- | | Nguyen | Zola (Hospital ID:) | 1996 |
2. INFUSION CONFIRMATION REPORT **TO:** Primary Health Care Professional: Pablo Dubois Fax #:
(913) 639-7813

FROM: Infusion Location: Harbour Medical Centre 5 Contact Person: Vivienne Hoffman Fax #: Phone #:
Ridgeway Family Health 4

3. IMMUNOSUPPRESSANTS (IF APPLICABLE) Dose: (blank) (mg, Frequency, and Route)
4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION Name of Northview Clinic 5:
Harbour Medical Centre 5 Highpark Health Centre Coordinator Name: Cubtf Lxnyym Phone #: 892
531 6328 Fax #: (284) 444-1640
5. INFUSION INFORMATION | Renflexis Dose Given: | Date of Infusion: | Lot # | Infusion Frequency: |
Next Infusion Scheduled | | :-- | :-- | :-- | :-- | :-- | | Weight 61.00kg / 134.48 lbs
500.00 mg
exact dose
Induction Dose: Yes [] No [X] | 29/01/2025 | Pte36361 | q8w | (blank) | | |
(DD/MM/YYYY) | | | (DD/MM/YYYY) |

TDM Serum Draw Completed : Not requested

| PREMEDICATION | PRESCRIBED | ADMINISTERED | | :-- | :-- | :-- | :-- | :-- | | **DOSE | ROUTE |**
DOSE | ROUTE | PATIENT REFUSED? |

INFUSION REACTION INFORMATION Was there an infusion reaction? : No Adverse Event Reported to
Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT | Last Blood Test Performed: (DD/MM/YYYY) | Last Referring Physician Visit:
(DD/MM/YYYY) | Next Referring Physician Visit: (DD/MM/YYYY) | | :-- | :-- | :-- | | (blank) | (blank) |
(blank) |
8. INFUSION ADMINISTRATION | Name of On-Call Medical Backup Physician: | Name of Infusion
Nurse: | Infusion Nurse's Signature/Date: | | :-- | :-- | :-- | | Dr. Gallardo | Vivienne Hoffman | (blank) |
| | | (DD/MM/YYYY) |

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Harbour Medical Centre 8 Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

S-7185261564 YX-4250843439

Crestwood Medical Group

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO: Primary Health Care Professional: Pablo Dubois Fax #: (913) 639-7813

FROM: Infusion Location: Harbour Medical Centre 5 Contact Person: Dalia Watanabe Fax #: 474 465 1025
Phone #: 474 465 1025

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Harbour Medical Centre 5 Highpark Health Centre Coordinator Name: Cubtf
Lxnyym Phone #: 892 531 6328 Fax #: (284) 444-1640

5. INFUSION INFORMATION

Renflexis Dose Given:	Date of Infusion: 09/03/2025	Lot # A0577584 A0577584	Infusion Frequency: Q 6 weeks	Next Infusion Scheduled 20/04/2025
Weight 62.00kg /136.69 lbs 500.00 mg exact dose Induction Dose: Yes [] No [X]	(DD/MM/YYYY)			(DD/MM/YYYY)

TDM Serum Draw Completed : Not requested

PREMEDICATION	PRESCRIBED	ADMINISTERED
	DOSE	ROUTE

INFUSION REACTION INFORMATION Was there an infusion reaction? : No Adverse Event Reported to
Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY) Unknown	Next Referring Physician Visit: (DD/MM/YYYY) Unknown
09/03/2025		

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician:	Name of Infusion Nurse:	Infusion Nurse's Signature/Date:
Vh. Usqxtfhrc	Dalia Watanabe	 (DD/MM/YY)

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Highpark Health Centre 4 Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

S-7185261564 YX-4250843439

Crestwood Medical Group

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO: Primary Health Care Professional: Pablo Dubois Fax #: (913) 639-7813

FROM: Infusion Location: Harbour Medical Centre 5 Contact Person: Emeka Popov Fax #: (289) 988-2775
Phone #: 233-583-8176

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Harbour Medical Centre 5 Phone #: 892 531 6328

Highpark Health Centre Coordinator Name: Cubtf Lxnyym Fax #: (284) 444-1640

5. INFUSION INFORMATION

Renflexis Dose Given: Weight 63.00kg /138.89 lbs 500.00 mg exact dose Induction Dose: Yes [] No [X]

Date of Infusion: 20/04/2025 (DD/MM/YYYY)

Lot # A0577584 [REDACTED-LOT-EXPIRY-DATE]

Infusion Frequency: q 6 weeks

Next Infusion Scheduled 01/06/2025 (DD/MM/YYYY)

TDM Serum Draw Completed : Not requested

PREMEDICATION	PRESCRIBED	ADMINISTERED
	DOSE	ROUTE

INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician:	Name of Infusion Nurse:	Infusion Nurse's Signature/Date:
Lucia Ashby	Emeka Popov	_____
		(DD/MM/YY)

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Highpark Health Centre 4 Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

S-7185261564 KR-3619062818

Crestwood Medical Group

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of birth: (DD/MM/YYYY)
Nguyen	Zola (Hospital ID:)	1996

2. INFUSION CONFIRMATION REPORT

TO: Primary Health Care Professional: Pablo Dubois Fax #: (913) 639-7813

FROM: Infusion Location: Harbour Medical Centre 5 Contact Person: Dalia Watanabe Fax #: 474 465 1025
Phone #: 219 255 9201

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: _____ (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Harbour Medical Centre 5 Phone #: 892 531 6328 Highpark Health Centre
Coordinator Name: Cubtf Lxnyym Fax #: (284) 444-1640

5. INFUSION INFORMATION

Renflexis Dose Given: Weight 63.20kg /139.33 lbs 500.00 mg exact dose Induction Dose: [] Yes [X] No

Date of Infusion: 01/06/2025 (DD/MM/YYYY)

Lot # E0744006 exp [REDACTED-DATE]

Infusion Frequency: Q 6 weeks

Next Infusion Scheduled 13/07/2025 (DD/MM/YYYY)

TDM Serum Draw Completed : Yes

PREMEDICATION	PRESCRIBED	ADMINISTERED
	DOSE	ROUTE

INFUSION REACTION INFORMATION Was there an infusion reaction? : No Adverse Event Reported to
Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY)	Next Referring Physician Visit: (DD/MM/YYYY)
Unknown	Unknown	Unknown

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician:	Name of Infusion Nurse:	Infusion Nurse's Signature/Date:
Dr. Zhang	Dalia Watanabe	 (DD/MM/YY)

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Harbour Medical Centre 8 Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

[REDACTED-DATE] 15:49:17 1/60 AUTO S1:F/T S2:LM S3:TIME 3.8 12.0 12.0 EC-760R-V/L 2E686K756
[image] Glenmore Specialist Centre 6 BL-7000 HT NR SE R-6013313431 5

[REDACTED-DATE] 15:49:17

1/60 AUTO

S1:F/T S2:LM S3:TIME

3.8 12.0 12.0 EC-760R-V/L 2E686K756

HT NR SE

Glenmore Specialist Centre 6 BL-7000 R-6013313431 3

[REDACTED-DATE] 15:49:17

1/60 (x) AUTO (x)

S1: F/T S2: LM S3: TIME

3.8 (12.0 / 12.0) EC-760R-V/L 2E686K756

[image]

• [?] [icon] HT NR SE [icon] [symbol]

Glenmore Specialist Centre 6 BL-7000 R-6013313431 [icon] 1

Aug 17, 2025 15:49:17 1/60 AUTO

[image]

S1: F/T S2: LM S3: TIME 3.8 12.0 12.0 EC-760R-V/L 2E686K756

HT NR SE

Glenmore Specialist Centre 6 BL-7000 R-6013313431 2

[REDACTED-DATE] 15:49:17

1/60 AUTO

S1: F/T S2: LM S3: TIME

3.8 12.0 12.0

EC-760R-V/L 2E686K756

HT NR SE

[REDACTED-DATE] 15:49:17 1/60 AUTO

[image]

S1:F/T S2:LM S3:TIME 3.8 (12.0/12.0) EC-760R-V/L 2E686K756 HT NR SE

Glenmore Specialist Centre 6 BL-7000 R-6013313431 7

[REDACTED-DATE] 15:49:17

1/60 AUTO

s1:F/T s2:LM s3:TIME 3.8 12.0 12.0 EC-760R-V/L 2E686K756

[image]

Glenmore Specialist Centre 6

HT NR SE

BL-7000 R-6013313431 6

[REDACTED-DATE] 15:49:17

1/60 [O] AUTO [O]

[image]

S1: F/T S2: LM S3: TIME

(3. 8) 12.0 12.0 EC-760R-V/L 2E686K756

- [grid icon] HT NR SE [arrow icon] [lightning icon]

Glenmore Specialist Centre 6 [sun icon] BL-7000 R-6013313431 [cylinder icon] 8

[REDACTED-DATE] 15:49:17

1/60 AUTO

S1:F/T S2:LM S3:TIME

3.8 [circle around 3.8] 12.0 12.0

EC-760R-V/L 2E686K756

[image]

-

HT NR SE f

Glenmore Specialist Centre 6 BL-7000 R-6013313431 10

[REDACTED-DATE] 15:49:17

1/60 AUTO

S1:F/T S2:LM S3:TIME

3.8 12.0 12.0

EC-760R-V/L 2E686K756

[image]

Glenmore Specialist Centre 6 BL-7000 R-6013313431 11

HT NR SE

[REDACTED-DATE] 15:49:17

1/60 (x) AUTO (x)

S1:F/T S2:LM S3:TIME

(3.8) 12.0 / 12.0 EC-760R-V/L 2E686K756

[image]

(*) [icon] HT NR SE (icon) (symbol)

Glenmore Specialist Centre 6 (sun icon) BL-7000 R-6013313431 (cylinder icon) 12

[REDACTED-DATE] 15:49:17 1/60 AUTO

[image]

S1: F/T S2: LM S3: TIME 3.8 12.0 12.0 EC-760R-V/L 2E686K756

HT NR SE

Glenmore Specialist Centre 6 BL-7000 R-6013313431 9

Fairlight Medical Centre 7 with you™ Support Program

FOR YOUR RECORDS

Program Enrollment SKYRIZI

TO: Dr. Pablo Dubois FAX: (913) 639-7813 DATE: Aug 20, 2025 PATIENT: Zola Nguyen PATIENT DATE OF BIRTH: MAR 16, 1996 PATIENT FILE NUMBER:

Dear Dr. Dubois,

This is to confirm that Fairlight Medical Centre 7 has received the enrollment form for your patient Zola Nguyen. Every Fairlight Medical Centre 7 patient is assigned a unique ID number. This patient's ID number is PR733715.

Fairlight Medical Centre 7 is now working to arrange drug plan coverage for SKYRIZI for your patient. Should we experience any undue delays in this process, you will be notified immediately.

Please do not hesitate to contact me if I can be of further assistance at 686.280.5949 ext. 4235 or (288) 543-4665.

Sincerely,

Emeka Popov Field Case Manager

[image] Fairlight Medical Centre 7 686.280.5949 ext. 4235 9 AM to 5 PM, [REDACTED-DATE] through Friday

[image] www.ridgewayfamilyhealthsouth.ca

[image] MEMBER OF Brookfield Medical Centre 4

Fairlight Medical Centre 7 with you™

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Fairlight Medical Centre 7™ with you™ Support Program

FOR YOUR RECORDS

Treatment Initiation Confirmation

SKYRIZI

TO: Dr. Pablo Dubois FAX: (913) 639-7813 DATE: Sep 7, 2025 PATIENT: Ms. Zola Nguyen PATIENT DATE OF BIRTH: MAR 16, 1996 PATIENT FILE NUMBER:

Dear Dr. Dubois,

We would like to inform you that your patient, Ms. Zola Nguyen, started SKYRIZI treatment on Aug 25, 2025.

Every Fairlight Medical Centre 7 patient is assigned a unique identification (ID) number. This patient's ID number is: PR733715.

Please do not hesitate to contact me at 686.280.5949 ext. 4235 or (288) 543-4665 if I can be of further assistance.

Sincerely,

Emeka Popov Field Case Manager

[image] Fairlight Medical Centre 7 686.280.5949 ext. 4235 9 AM to 5 PM, [REDACTED-DATE] through Friday

[image] www.ridgewayfamilyhealthsouth.ca

[image] MEMBER OF Brookfield Medical Centre 4

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Birchwood Care Clinic

Birchwood Care Clinic

Ontario [image]

Crestwood Medical Group Sunnymede Family Practice 2 737 Inglewood Ave New Brunswick ON J4T 3T6

Telephone: (688) 732-3828 Toll Free: (688) 732-3828 Facsimile: (965) 222-4398 Facsimile Toll Free: (965) 222-4398

Crestwood Medical Group Sunnymede Family Practice 2 737 Inglewood Ave New Brunswick ON J4T 3T6

Téléphone: (688) 732-3828 Sans frais: (688) 732-3828 Télécopieur: (965) 222-4398 Télécopieur sans frais: (965) 222-4398

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10/Sep/2025

Fairlight Medical Centre 2

NOTICE OF APPROVAL

To: Dr. Pablo Dubois Fax: (913) 639-7813

Responses are faxed to the requesting prescriber's office. Please include your fax number on all correspondence.

Re: Zola Nguyen Date of Birth: 1996

To ensure confidentiality, ministry replies identify the patient by first name, initial of the last name and date of birth. Please provide a copy of this letter to the patient and to the patient's pharmacy as a record of the decision for this request and the period of approval.

Drug Request Number: 00745027-26 Generic Drug: risankizumab

The Fairlight Medical Centre 2 (EAP) facilitates access to drugs that are not listed on the Brookfield Medical Centre 4 (ODB) Formulary for requests that meet specified criteria.

The request has been reviewed in accordance with the established ministry policies and approval has been granted. The coverage period begins as of the effective date and extends to the specified expiry date and includes the backdated period of coverage explained in further detail below. In order to receive coverage, the patient must be eligible to receive benefits under the ODB program.

DIN/PIN	Brand Name	Effective Date	Expiry Date
02532093	Skyrizi 150mg/mL inj Packaging:prefilled cartridge	2025-07-08	2026-03-10

DIN/PIN	Brand Name	Effective Date	Expiry Date
02532107	Skyrizi 60mg/mL inj Packaging:vial	2025-07-08	2026-03-10

Generic substitution policies apply to EAP products. Pharmacists should refer to the e-formulary for a list of other possible interchangeable product(s) for the approved drug(s) listed above which may be dispensed.

This request for reimbursement of risankizumab for Crohn's disease was reviewed by an external medical reviewer. Based on the information provided, approval of funding has been granted.

The recommended dose is 600 mg administered by intravenous infusion at Week 0, Week 4, and Week 8, followed by 360 mg administered by subcutaneous injection at Week 12, and every 8 weeks thereafter as maintenance.

Please refer to the product monograph for full prescribing information.

For renewal, please provide the following information as objective evidence of benefit from therapy:

- Date and findings of the most recent assessment.
- Comparison of the patient's clinical status pre- and post-risankizumab, including a comparison of the Harvey Bradshaw Index (HBI) score (or other validated disease activity score) and/or fistulae status, the patient's weight, details of bleeding, and biochemical improvement (e.g., hemoglobin, hematocrit, platelet count, C reactive protein or ESR).
- If the patient has been receiving biologic therapy for more than two years: details from last year's clinical assessment (including the HBI score or other validated disease activity score) to demonstrate preservation of treatment effectiveness.
- Treatment plan (including the dose and frequency of risankizumab requested).
- A list of the patient's current concomitant medications with the dose and frequency of administration for each agent. Details of prednisone usage/tapering must be provided.

Please note risankizumab will not be funded in combination with another biologic used to treat inflammatory bowel disease.

The effective date of an EAP approval is the date the clinical decision was made or 30 business days from the date the request was received by the program, whichever is later. This is to recognize that prescribers may not be able to submit an EAP request at the same time as the clinical decision to prescribe a drug is made.

Not all EAP approvals are eligible for backdating and not all EAP requests are approved for coverage. Patients should be informed that out-of-pocket costs for EAP drugs purchased prior to an EAP decision will only be reimbursed if the request is approved, and only for the days between the effective date and expiry date.

Please inform your patient that eligible ODB costs for this drug that may have been purchased between the effective date and the expiry date may be considered for reimbursement if the original prescription receipt(s) is (are) submitted to one of the following addresses:

00745027-26

2025-09-10 00:10:59 3 /3

For Highpark Health Centre 4 registrants*: 148 Inglewood Ave Moncton 3 ON N6G 2E4 Tel: 761-848-1936 or 761-848-1936

For other ODB recipients: 201 River Ave Moncton 3 ON N6G 2E4 Tel: 477-864-5220 or 477-864-5220

*Trillium clients whose receipts have already been submitted and rejected prior to receiving this response letter should call the number provided above and request their receipts to be re-processed.

Should an extension of coverage be required, please provide complete information to address the renewal criteria in a timely manner to avoid a gap in coverage.

As of Nov 13, 2021 Ontario prescribers, their designates and delegates can access decision letters to their previous and new EAP requests online through SADIE.

Ontario prescribers, their designates and delegates can create and submit requests to the program online through SADIE. Visit <https://www.maplehealthclinic.ca> for more information.

Start using SADIE now for faster decisions. Results show 75% fewer requests for additional information, with response times 50% faster than the faxed based process.

Sincerely,

Noah Yamamoto Director, Sunnymede Family Practice 2

For more information about the Fairlight Medical Centre 2 please visit our website at <https://www.maplehealthclinic.ca>

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00745027-26

2025/09/16 10:37:43 1 /3

Birchwood Care Clinic Birchwood Care Clinic Ontario [logo]

Crestwood Medical Group Sunnymede Family Practice 2 737 Inglewood Ave New Brunswick ON J4T 3T6

Crestwood Medical Group Sunnymede Family Practice 2 737 Inglewood Ave New Brunswick ON J4T 3T6

Telephone: 487.996.2056 Toll Free: 487.996.2056 Facsimile: 740.918.5889 Facsimile Toll Free:
740.918.5889

Téléphone: 487.996.2056 Sans frais: 487.996.2056 Télécopieur: 740.918.5889 Télécopieur sans frais:
740.918.5889

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16/Sep/2025

Fairlight Medical Centre 2

NOTICE OF APPROVAL

To: Dr. Pablo Dubois Fax: (913) 639-7813

Responses are faxed to the requesting prescriber's office. Please include your fax number on all correspondence.

Re: Zola Nguyen Date of Birth: 1996

To ensure confidentiality, ministry replies identify the patient by first name, initial of the last name and date of birth. Please provide a copy of this letter to the patient and to the patient's pharmacy as a record of the decision for this request and the period of approval.

Drug Request Number: 75673371-55 Generic Drug: risankizumab

The Fairlight Medical Centre 2 (EAP) facilitates access to drugs that are not listed on the Brookfield Medical Centre 4 (ODB) Formulary for requests that meet specified criteria.

The request has been reviewed in accordance with the established ministry policies and approval has been granted. The coverage period begins as of the effective date and extends to the specified expiry date and includes the backdated period of coverage explained in further detail below. In order to receive coverage, the patient must be eligible to receive benefits under the ODB program.

DIN/PIN	Brand Name	Effective Date	Expiry Date
02532093	Skyrizi 150mg/mL inj	2025-07-08	2026-03-10
	Packaging:prefilled cartridge		

DIN/PIN	Brand Name	Effective Date	Expiry Date
02532107	Skyrizi 60mg/mL inj	2025-07-08	2026-03-10
	Packaging:vial		

Generic substitution policies apply to EAP products. Pharmacists should refer to the e-formulary for a list of other possible interchangeable product(s) for the approved drug(s) listed above which may be dispensed.

This request for reimbursement of risankizumab for Crohn's disease was reviewed by an external medical reviewer. Based on the information provided, approval of funding has been granted.

The recommended dose is 600 mg administered by intravenous infusion at Week 0, Week 4, and Week 8, followed by 360 mg administered by subcutaneous injection at Week 12, and every 8 weeks thereafter as maintenance.

Please refer to the product monograph for full prescribing information.

For renewal, please provide the following information as objective evidence of benefit from therapy:

- Date and findings of the most recent assessment.
- Comparison of the patient's clinical status pre- and post-risankizumab, including a comparison of the Harvey Bradshaw Index (HBI) score (or other validated disease activity score) and/or fistulae status, the patient's weight, details of bleeding, and biochemical improvement (e.g., hemoglobin, hematocrit, platelet count, C reactive protein or ESR).
- If the patient has been receiving biologic therapy for more than two years: details from last year's clinical assessment (including the HBI score or other validated disease activity score) to demonstrate preservation of treatment effectiveness.
- Treatment plan (including the dose and frequency of risankizumab requested).
- A list of the patient's current concomitant medications with the dose and frequency of administration for each agent. Details of prednisone usage/tapering must be provided.

Please note risankizumab will not be funded in combination with another biologic used to treat inflammatory bowel disease.

The effective date of an EAP approval is the date the clinical decision was made or 30 business days from the date the request was received by the program, whichever is later. This is to recognize that prescribers may not be able to submit an EAP request at the same time as the clinical decision to prescribe a drug is made.

Not all EAP approvals are eligible for backdating and not all EAP requests are approved for coverage. Patients should be informed that out-of-pocket costs for EAP drugs purchased prior to an EAP decision will only be reimbursed if the request is approved, and only for the days between the effective date and expiry date.

Please inform your patient that eligible ODB costs for this drug that may have been purchased between the effective date and the expiry date may be considered for reimbursement if the original prescription receipt(s) is (are) submitted to one of the following addresses:

2025/09/16 10:37:43 3 /3

For Highpark Health Centre 4 registrants*: 148 Inglewood Ave Moncton 3 ON N6G 2E4 Tel: 487.996.2056 or 487.996.2056

For other ODB recipients: 201 River Ave Moncton 3 ON N6G 2E4 Tel: 487.996.2056 or 487.996.2056

*Trillium clients whose receipts have already been submitted and rejected prior to receiving this response letter should call the number provided above and request their receipts to be re-processed.

Should an extension of coverage be required, please provide complete information to address the renewal criteria in a timely manner to avoid a gap in coverage.

As of Nov 13, 2021 Ontario prescribers, their designates and delegates can access decision letters to their previous and new EAP requests online through SADIE.

Ontario prescribers, their designates and delegates can create and submit requests to the program online through SADIE. Visit <https://www.maplehealthclinic.ca> for more information.

Start using SADIE now for faster decisions. Results show 75% fewer requests for additional information, with response times 50% faster than the faxed based process.

Sincerely,

Gina Xiong Director, Sunnymede Family Practice 2

For more information about the Fairlight Medical Centre 2 please visit our website at <https://www.glenmorespecialistcentre.ca>

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75673371-55

Riverside Medical Centre 3*

FAX

TO: Dr. Pablo Dubois FAX NUMBER: (913) 639-7813

FROM: Riverside Medical Centre 3 FAX NUMBER: 859-781-7235 DATE: 2025-09-23 TOTAL NO. OF PAGES INCLUDING COVER: 1

RE: Non-Compliant Patient for Calprotectin Test

We would like to advise you that our laboratory has not received a stool sample for the Calprotectin test from the following patient:

Patient ID: PR733715 Name: Zola Nguyen DOB: 1996

Our National Specialty Service Support Team has made several follow-up calls remind them to send their sample and to answer their questions.

For any questions, please contact us at 428-674-2688.

Thank you, Harbour Medical Centre 9 428-674-2688

This facsimile is intended for the addressee and contains confidential and/or personal health information. Any dissemination, distribution, or copying of this information is strictly prohibited. If you have received this transmission in error, please notify us immediately 428-674-2688 to arrange for the return of the transmitted documents or to ensure their proper destruction.

S-7185261564 RQ-7466567185

Crestwood Medical Group

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient: Nguyen First Name of Patient: Zola (Hospital ID:) Date of birth: (DD/MM/YYYY)
1996

2. INFUSION CONFIRMATION REPORT

TO: Primary Health Care Professional: Pablo Dubois Fax #: (913) 639-7813

FROM: Infusion Location: Harbour Medical Centre 5 Contact Person: Dalia Watanabe Fax #: 474 465 1025
Phone #: 219 255 9201

3. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: (mg, Frequency, and Route)

4. Cedar Specialist Group 2 AND COORDINATOR INFORMATION

Name of Northview Clinic 5: Harbour Medical Centre 5 Highpark Health Centre Coordinator Name: Cubtf
Lxnyym Phone #: 892 531 6328 Fax #: (284) 444-1640

5. INFUSION INFORMATION

Renflexis Dose Given: Weight 63.00kg /138.89 lbs 500.00 mg exact dose Induction Dose: Yes [] No [X]

Date of Infusion: 13/07/2025 (DD/MM/YYYY)

Lot # jkf19080 ub 7248 exp [REDACTED-DATE]

Infusion Frequency: Q 6 Weeks

Next Infusion Scheduled 25/08/2025 (DD/MM/YYYY)

TDM Serum Draw Completed : Not requested

| PREMEDICATION | PRESCRIBED | ADMINISTERED | | :--- | :--- | :--- | :--- | :--- | | DOSE | ROUTE |
DOSE | ROUTE | PATIENT REFUSED? |

INFUSION REACTION INFORMATION

Was there an infusion reaction? : No Adverse Event Reported to Manufacturer? : Not Applicable

7. PLEASE ASK PATIENT

Last Blood Test Performed: (DD/MM/YYYY)	Last Referring Physician Visit: (DD/MM/YYYY) Unknown	Next Referring Physician Visit: (DD/MM/YYYY) Unknown
Unknown		

8. INFUSION ADMINISTRATION

Name of On-Call Medical Backup Physician: Dr. Gallardo Name of Infusion Nurse: Dalia Watanabe Infusion Nurse's Signature/Date:

(DD/MM/YY)

This form contains confidential and personal information and is intended only for the individual or entity named in the address. If you are not the intended recipient and have received this form in error, please notify the sender and delete this form. Unauthorized use or disclosure of this form is prohibited and may be unlawful.

Highpark Health Centre 4 | Alberta | New Brunswick, ON | N8J 5H2 | www.northviewclinicnorth.ca ©
Highpark Health Centre 4 and its affiliates 2025 | All trademarks used under license. | MEMBER OF
Brookfield Medical Centre 4

Harbour Medical Centre 8 Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

Birchwood Care Clinic 9

FOR SPECIALIZED TREATMENT

Post Infusion Report

Patient ID PR733715 **Patient Name:** Zola Nguyen **DOB:** MAR 16, 1996 **Sex:** F **Address:** 766 Fennimore Ave Nanaimo ON, Canada **OHIP:** 1287070723LW **Home Phone:** (919) 340-3971 ext. cell

Prescribing Physician: Dr. Pablo Dubois **Pharmacy:** Fax #: (457) 550-6517 **Attending Physician:** Dr. Zeynep Thibault

Pre-infusion/Injection check list completed: ☒ YES ☐ NO

Latest Infusion Location: Birchwood Care Clinic 9

Drug: SKYRIZI 600MG Previous infusion: 2025-Apr-20: MULTPLE **CONDITION:** Crohn's

Infusion		Drug		Infusion				
#	Date	Dose (mg)	Weight (kg)	Start Hour	Start Minute	End Hour	End Minute	Length (min)
LD#1	2025-Aug-25	600	63	09	45	10	45	60.00

Pre-Medication	Dose (mg)	Route	Pre-Medication	Dose (mg)	Route
☐ Solucortef		IV	☐ Gravol		
☐ Tylenol		PO	☐ Benadryl		
☐ Aeries		PO	☐ Methylprednisolone		
☐ Cetirizine		PO	☐ Famotidine		

Patient's Skyrizi IV administered successfully with no reaction(s): ☒ YES ☐ NO

AE Report Submitted: ☐ NO ☐ YES **ADVERSE EVENT SUBMISSION CONFIRMATION #** [blank]

TDM completed ☐ **Last Blood Test Performed:** MMM-DD-YYYY **Last Referring Physician Visit:** MMM-DD-YYYY **Next Scheduled Infusion/Injection:** Sep 22, 2025 **Next Referring Physician Visit:** MMM-DD-YYYY

NOTES: LOT # 1310405 EXP 2027AL02

Nurse: Watanabe, Dalia Nanaimo **Nurse Signature:** [signature]

If you have any questions, please contact: zeynep.thibault24@birchwoodcareclinic.ca

Harbour Medical Centre 10

Post Infusion Report

Patient ID: PR733715 Patient Name: Zola Nguyen DOB: MAR 16, 1996 Sex: F Address: 766 Fennimore Ave Nanaimo ON, Canada OHIP: 1287070723LW Home Phone: (919) 340-3971 ext. cell

Prescribing Physician: Dr. Pablo Dubois Pharmacy: Fax #: (457) 550-6517 Attending Physician: Dr. Zeynep Thibault

Pre-infusion/Injection check list completed: ☒ YES ☐ NO

Latest Infusion Location: Birchwood Care Clinic 9

Drug: SKYRIZI 600MG LD#2 Previous infusion: 2025-Aug-25: LD#1

CONDITION: Crohn's

Infusion		Drug		Infusion				
#	Date	Dose (mg)	Weight (kg)	Start Hour	Start Minute	End Hour	End Minute	Length (min)
LD#2	2025-Sep-22	600	63	15	40	16	40	60.00

Pre-Medication	Dose (mg)	Route	Pre-Medication	Dose (mg)	Route
☐ Solucortef		IV	☐ Gravol		
☐ Tylenol		PO	☐ Benadryl		
☐ Aeries		PO	☐ Methylprednisolone		
☐ Cetirizine		PO	☐ Famotidine		

Patient's Skyrizi IV administered successfully with no reaction(s): ☒ YES ☐ NO

AE Report Submitted: ☒ NO ☐ YES ADVERSE EVENT SUBMISSION CONFIRMATION #

TDM completed ☐

Last Blood Test Performed: MMM-DD-YYYY Last Referring Physician Visit: MMM-DD-YYYY Next Scheduled Infusion/Injection: Oct 20, 2025 Next Referring Physician Visit: MMM-DD-YYYY

NOTES: 4991319 [REDACTED-DATE]

Nurse: Popov, Emeka Northview Clinic 9 Nurse Signature: Emeka Popov

If you have any questions, please contact: zeynep.thibault24@birchwoodcareclinic.ca Birchwood Care Clinic 9 368 Larchmont Ave, Guelph 2, ON, V7L 3A9 P: 985 218 6448 Page 1 of 1 : 985 218 6448 Patient:

Zola Nguyen PHN: 1287070723LW DOB: 1996

Post Infusion Report

Patient ID PR733715 **Patient Name:** Zola Nguyen **DOB:** MAR 16, 1996 **Sex:** F **Address:** 766 Fennimore Ave Nanaimo ON, Canada **OHIP:** 1287070723LW **Home Phone:** (919) 340-3971 ext. cell

Prescribing Physician: Dr. Pablo Dubois **Pharmacy:** Fax #: (457) 550-6517 **Attending Physician:** Dr. Zeynep Thibault

Pre-infusion/Injection check list completed: ☒ YES ☐ NO

Latest Infusion Location: Birchwood Care Clinic 9 **Drug:** Skyrizi LD #3 **Previous infusion:** 2025-Sep-22: LD#2 **CONDITION:** Crohn's

Infusion		Drug		Infusion				
#	Date	Dose (mg)	Weight (kg)	Start Hour	Start Minute	End Hour	End Minute	Length (min)
#3	2025-Oct-20	600	63	18	15	19	15	60.00

Pre-Medication	Dose (mg)	Route	Pre-Medication	Dose (mg)	Route
☐ Soluortef		IV	☐ Gravol		
☐ Tylenol		PO	☐ Benadryl		
☐ Aeries		PO	☐ Methylprednisolone		
☐ Cetirizine		PO	☐ Famotidine		

Patient's Skyrizi IV administered successfully with no reaction(s): ☒ YES ☐ NO

AE Report Submitted: ☒ NC ☐ YES **ADVERSE EVENT SUBMISSION CONFIRMATION #** ☐

TDM completed ☐

Last Blood Test Performed: MMM-DD-YYYY **Last Referring Physician Visit:** MMM-DD-YYYY **Next Scheduled Infusion/Injection:** Nov 18, 2025 **Next Referring Physician Visit:** MMM-DD-YYYY

NOTES: Lot # Pte36361 exp. [REDACTED-DATE]

Nurse: Blackwood, Nadia RN Nanaimo **Nurse Signature:** Alden Andersen RN

If you have any questions, please contact: zeynep.thibault24@birchwoodcareclinic.ca

! [Harbour Medical Centre 10 logo]

Injection Training Report

PATIENT ID: PR733715

Patient Name: Zola Nguyen DOB: 1996 Sex: F Address: 766 Fennimore Ave Nanaimo ON, Canada OHIP: 1287070723LW Home Phone: (919) 340-3971 ext. cell

Prescribing Physician: Dr. Pablo Dubois Pharmacy: Westbrook Medical Associates Attending Physician: Dr. Emeka Popov Birchwood Care Clinic 9 Location: Birchwood Care Clinic 9

Date: Drug: Skyrizi Dose: 360 mgs Frequency: Q8W Condition: drug education provided by Glenmore Specialist Centre 6 pharmacist

Today's Injection: # 1

Y N Pre-injection check list: [] ☐ Adverse reaction(s) to previous injection(s), pre-medication: [] ☐
Current open wound, infection, fever, flu-like illness or antibiotic use [] ☐ Recent/upcoming live
vaccination, dental work, surgery [] ☐ Unusually sore, hot, red, swollen joints [] ☐ Notes or other
concerns (ie. signs of CHF or kn; breast-feeding / pregnant)

Injection site: right abdomen Injection time: 16 : 00 PM Injection completed by: patient Post-injection
monitoring: not required

☐ Patient's injection was administered successfully with no reaction(s) [] Adverse reaction(s) details: Lot#: tna12178 kx 6766 Exp: [REDACTED-DATE]

Notes: ☐ Education provided regarding storage, handling and disposal ☐ Review of injection technique, potential side-effects

patient will continue at home with injection schedule. Using OBI. comfortable with procedure.

Next prescribing physician appt .

Next Scheduled Injection: not applicable, home injections arranged

Health Care Professional Name: Nadia Blackwood Glenmore Specialist Centre 6 Professional signature:
Nadia Blackwood

Brookfield Medical Centre 8 711 Sherwood Ave, Guelph 2, ON, V7L 3A9 P: (444) 740-6747 [illegible]
(444) 740-6747

Patient: Zola Nguyen PHN: 1287070723LW DOB: 1996

Birchwood Care Clinic Birchwood Care Clinic Ontario [image]

Crestwood Medical Group Sunnymede Family Practice 2 330 Glenarm Blvd 330 Glenarm Blvd ON 330 Glenarm Blvd

Crestwood Medical Group Sunnymede Family Practice 2 330 Glenarm Blvd 330 Glenarm Blvd ON 330 Glenarm Blvd

Telephone:	(749) 476-8640	Téléphone :	(749) 476-8640
Toll Free:	(749) 476-8640	Sans frais:	(749) 476-8640
Facsimile:	(749) 476-8640	Télécopieur:	(749) 476-8640
Facsimile Toll Free:	(749) 476-8640	Télécopieur sans frais:	(749) 476-8640

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29/Jan/2026 Fairlight Medical Centre 2

NOTICE OF APPROVAL

To: Dr. Pablo Dubois Fax: (749) 476-8640

Responses are available in SADIE and will be faxed to the requesting prescriber's office.

Re: Zola Nguyen Date of Birth: 1996

To ensure confidentiality, ministry replies identify the patient by first name, initial of the last name and date of birth. Please provide a copy of this letter to the patient and to the patient's pharmacy as a record of the decision for this request and the period of approval.

Drug Request Number: 90894672-09 Generic Name: risankizumab

The Fairlight Medical Centre 2 (EAP) facilitates access to drugs that are not listed on the Brookfield Medical Centre 4 (ODB) Formulary for requests that meet specified criteria.

The request has been reviewed in accordance with the established ministry policies and approval

has been granted. The coverage period begins as of the effective date and extends to the specified expiry date. In order to receive coverage, the patient must be eligible to receive benefits under the ODB program.

DIN/PIN	Brand Name	Effective Date	Expiry Date
02532107	Skyrizi 60mg/mL inj Packaging: vial	2026-03-11	2027-03-11
02532093	Skyrizi 150mg/mL inj Packaging: prefilled cartridge	2026-03-11	2027-03-11

Generic substitution policies apply to EAP products. Pharmacists should refer to the e-formulary for a list of other possible interchangeable product(s) for the approved drug(s) listed above which may be dispensed.

This request for reimbursement of risankizumab for Crohn's disease was reviewed. Based on the information provided, approval of funding has been granted.

The recommended dose is 600 mg administered by intravenous infusion at Week 0, Week 4, and Week 8, followed by 360 mg administered by subcutaneous injection at Week 12, and every 8 weeks thereafter as maintenance.

Please refer to the product monograph for full prescribing information.

For renewal, please provide the following information as objective evidence of benefit from therapy:

- Date and findings of the most recent assessment.
- Comparison of the patient's clinical status pre- and post-risankizumab, including a comparison of the Harvey Bradshaw Index (HBI) score (or other validated disease activity score) and/or fistulae status, the patient's weight, details of bleeding, and biochemical improvement (e.g., hemoglobin, hematocrit, platelet count, C reactive protein or ESR).
- If the patient has been receiving biologic therapy for more than two years: details from last year's clinical assessment (including the HBI score or other validated disease activity score) to demonstrate preservation of treatment effectiveness.
- Treatment plan (including the dose and frequency of risankizumab requested).
- A list of the patient's current concomitant medications with the dose and frequency of administration for each agent. Details of prednisone usage/tapering must be provided.

Please note risankizumab will not be funded in combination with another biologic used to treat inflammatory bowel disease.

Should an extension of coverage be required, please provide complete information to address the renewal criteria in a timely manner to avoid a gap in coverage

90894672-09

Sincerely,

Gina Xiong Director, Sunnymede Family Practice 2

For more information about the Fairlight Medical Centre 2 please visit our website at <https://www.crestwoodmedicalgroup.ca>

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90894672-09

Riverside Medical Centre 3*

FAX

TO: Dr. Pablo Dubois FAX NUMBER: (749) 476-8640

FROM: Riverside Medical Centre 3 FAX NUMBER: (885) 271-3459 14 DATE: 2026-06-16 TOTAL NO. OF PAGES INCLUDING COVER: 1

RE: Non-Compliant Patient for Calprotectin Test

We would like to advise you that our laboratory has not received a stool sample for the Calprotectin test from the following patient:

Patient ID: PR733715 Name: Zola Nguyen DOB: 1996

Our Ayesha Whitfield has made several follow-up calls remind them to send their sample and to answer their questions.

For any questions, please contact us at 812.917.7918.

Thank you, Ayesha Whitfield 812.917.7918

This facsimile is intended for the addressee and contains confidential and/or personal health information. Any dissemination, distribution, or copying of this information is strictly prohibited. If you have received this transmission in error, please notify us immediately 812.917.7918 to arrange for the return of the transmitted documents or to ensure their proper destruction.

Riverside Medical Centre 3 (TM) SCC Accredited LAB LAB Accredited CON

Lab ID: 3547-0670830 External Ref. No.: Patient ID: PR733715

Prescriber

Name: Pablo Dubois **Clinic:** Cedar Specialist Group 5 **Address:** 285 Victoria St112 Aldergrove Ave
Telephone: 487.996.2056 **Fax:** 740.918.5889

Patient

Name: Nguyen, Zola **Date of birth:** 1996 **Age:** 30 **Sex:** F **Health Ins.:** 7123642028

Biochemistry

Analysis	Specimen	Result	Reference value	Unit	Status
Calprotectin	Stool	429	<100	µg/g	

[image: graph showing calprotectin results over time]

Collection date	Result (µg/g)
2020-11-22	674
2021-04-07	272
2022-05-31	888
2023-02-20	1334
2026-06-30	429

Interpretation: Active inflammation in the gastrointestinal tract. It is recommended to order additional analyses and to optimize the curative treatment under the supervision of medical specialists.

Note: The cut-off level suggested for adults (100 µg/g) can also be used for children aged 4 to 17 years regardless of sex.

Method: Reference values:

Normal: < 100 µg/g Moderate inflammation: ≥ 100 - ≤ 250 µg/g Active inflammation: > 250 µg/g

Reference: Bressler B. et al. Clinicians' guide to the use of fecal calprotectin to identify and monitor disease activity in inflammatory bowel disease. *Can J Gastroenterol Hepatol.* 2015 29(7):369-72.

Fecal calprotectin quantification is performed with the Buhlmann fCAL Turbo immunoturbidimetric assay and the Roche COBAS c311 analyzer.

The performance characteristics of this test performed on the Roche COBAS c311 analyzer have been validated by Riverside Medical Centre 3. This test is approved by the Therapeutic Products Directorate (TPD) of Health Canada for application on other analyzers.

Moderate elevations of fecal calprotectin may be seen in patients taking non-steroidal anti-inflammatory drugs, aspirin, or proton pump inhibitors. If moderate inflammation is present, it is suggested to repeat the test in 4 to 6 weeks.

Date Collected	Date Received	Partial report	Completed report	Revised report
2026-06-30	[REDACTED-DATE]	-	2026-07-06	

825 Birch Ave, Edmonton 2 (QC) Canada G9D 1Z8 T 640.721.9849 F 765.482.3603 Page 1 of 2

Riverside Medical Centre 3

SCC Accredited LAB LAB Accrédité CCN TM

Lab ID: 3547-0670830 External Ref. No.: Patient ID: PR733715

Prescriber	Patient
Name: Pablo Dubois	Name: Nguyen, Zola
Clinic: Cedar Specialist Group 5	
Address: 171 Victoria St Nanaimo, ON A6G 3K2	Date of birth: 1996 Age: 30
Telephone: 487.996.2056	Sex: F
Fax: 740.918.5889	Health Ins.: 7123642028

Biochemistry

Analysis	Specimen	Result	Reference value	Unit	Status
----------	----------	--------	-----------------	------	--------

Moderate to marked increases in fecal calprotectin may be seen in other conditions unrelated to inflammatory bowel disease when there is an increase in neutrophils, monocytes, or macrophages (including celiac disease, colorectal cancer and gastrointestinal infections).

Due to the lack of homogeneous distribution of calprotectin in feces, variability in results may be observed when patients are monitored over time, particularly in samples with high calprotectin concentrations.

!signature] Esme Zhang, Ph.D, DEPD, CSPQ Clinical Biochemist

Date Collected	Date Received	Partial report	Completed report	Revised report
2026-06-30	[REDACTED-DATE]	-	2026-07-06	-

825 Birch Ave, Edmonton 2 (QC) Canada G9D 1Z8 T 653.565.9295 F 950.211.6795 Page 2 of 2

Riverside Medical Centre

Riverside Medical Centre 4 115 Sherwood Blvd, Nanaimo, ONTARIO T8X 0V9 (444) 426-4137

EMERGENCY REPORT CHART COPY

HOSPITAL #: 0745 PATIENT'S SURNAME: Nguyen PATIENT'S FIRST NAME: Zola Nguyen QUKSRPS
TDXPGS: CP642789/08 UNIT NUMBER: Q897863084 BIRTHDATE: 1996 AGE: 20 SEX: F MEDICAL
ALERTS: REG'N TIME: 1037 ADMIT DATE: 16/09/2016 AMB: N A. MODE: W H.C. NUMBER & V.C.: 0745
Cedar Specialist Group 6 C.D.: 50 STREET ADDRESS: 579 Harlow Blvd RES. CODE: 0745 PERSON TO
NOTIFY: Martin, Idris RELATIONSHIP: MOTHER CLERK: SPIE CITY: Nanaimo PROV: ON POSTAL
CODE: H1L 7N8 HOME PHONE: (919) 340-3971 PRIMARY INSURER, POLICY NO., COVERAGE NO.:
Cedar Specialist Group 6 0745 SMOKER?: N WORK PHONE: FAMILY PHYSICIAN: NO PHYSICIAN
SECURITY ALERTS: CURRENT Cedar Specialist Group 6?: No SIN#: DATE, TIME OF ACCIDENT:

ISOLATION: None STATED COMPLAINT: ABDOMINAL DISCOMFORT X ONE MONTH MEDICAL
DIRECTIVE: Grimaldi Abdo Female

TRIAGE LEVEL: 4 TRIAGE TIME: 1031 ALLERGIES: ☐

VITALS AT TRIAGE: ROOM: [blank] BN: [blank] TEMP: 36.8 PULSE: 72 RESP: 16 BP: 106/70 O2 SAT:
100 FI02: Room Air WT (kg): 42.2

HISTORY OF PRESENT ILLNESS / INJURY: ABDOMINAL DISCOMFORT X ONEMONTH PT HAS
NOTED ABDOMINAL DISCOMFORT TO RIGHT UPPER RIB CAGE X ONE MONTH; HAS BEEN SEEN
@ WALK IN CLINIC X 2 FOR THIS; AWAITING ULTRASOUND FOR SAME; NO CHANGE IN APPETITE;
NO VOMITING

PAST MEDICAL HX: ☐

☐ Vaginal D/C. ☐ SOB ☐ cough. ☐ Menses [illegible]. ☐ palpitations.

ORDERED	SENT
EKG ☐	☐
CBC ☒	☐
L/C, Glucose ☒	☐
CK/TNI ☐	☐
INR/PT ☐	☐
LFTs ☒	☐
Albumin ☐	☐
Amylase ☒	☐
VBGs ☐	☐
Lactate ☐	☐
Blood cx x2 ☐	☐

ORDERED	SENT
CA, MG, PO4 [X]	[]

MEDICATIONS / LIST ATTACHED: [X] ☐

MD ASSESSMENT TIME 1130 [X] NOTE DICTATED Intermittent - RUQ pain x 1 body x 2 yesterday. worse today. Nausea - resolved. Did not notice Δ with food

O/E Atx x 3 Anicteric - [Diagram of abdomen with six regions, marked with a triangle in the top right region]
(+) BS Imp Cholelithiasis Tender ☐ rebound

Urine [] Dip [] R&M [] C&S

ORDERS TIME

- EOM/U/S RUQ ? Cholecystitis

√ Buscopan 20 mg PO now.

√ [illegible] / IV D [illegible]

Pt may sit in chairs

** FAX CHART TO Dr Gallardo 455 PM As discussed by phone. TO D/W Sx. Dr Gallardo →
Choledocholithiasis For ERCP

R/A 13:55 multiple gallstones with 0.3cm stone in Distal common Bile duct ☐ pain WBC 7.3 Hb 141 T. Bil 14. HCG < 2. Suggested GI consult Amylase (N)

DIAGNOSIS: Cholelithiasis + Choledocholithiasis

TREATMENT PLAN / DISCHARGE INSTRUCTIONS: Book for Tuesday. morning expect 3 hr. low fat / clean diet - return if fever / chills / worse pain RX Provided []

CONSULTANT: Gallardo TIME CALLED: 1655 TIME RESPONDED: 1655

CONSULTANT: Gallardo TIME CALLED: 1656 TIME RESPONDED:

FOLLOW-UP: [] FamMD [] ER [] Other [blank] if persists [blank] if worsens [blank] in [blank] days

DISPOSITION (Circle One): [X] Home [] Transferred [] Admit [] LWBS [] DIED/DOA Date: 16/09/2016
Time: 1700 Staff Physician's Signature: [signature] Staff Physician (Please Print): [REDACTED-
PROVIDER-NAME]

TIME LEFT ER: [blank] [] R.EDFACE [] Follow Up Call Resident/Student's Signature: [blank] Resident / Student (Please Print): [blank]

9000/1000

Ord: Gallardo, Oona
Fam: NO PHYSICIAN
Att:
Oth:

Nguyen, Zola
579 Harlow Blvd
Nanaimo, ON
H1L 7N8
(760) 781-3742

REQ#: 0745
PHBA#: GD145786/89
UNIT#: Q897863084
DOB: 1996
AGE: 20
LOCN: R.ER

Date of OR:

DATE OF EXAM: 16/09/2016 SPIE ABDOMINAL ULTRASOUND COMPLETE

Signed REPORT

PROCEDURE: ABDOMINAL ULTRASOUND COMPLETE

CLINICAL HISTORY: Right upper quadrant pain

FINDINGS:

There are multiple gallstones identified within the gallbladder. Wall is not thickened. No pericholecystic fluid is visualized.

The biliary tree is nondilated. There is however a small echogenic focus with suspected shadowing measuring 0.3 cm within the distal common bile duct.

Solid organs are unremarkable. There is no free fluid identified.

IMPRESSION:

1. Cholelithiasis without evidence of cholecystitis.
2. Choledocholithiasis with a 0.3 cm calculus identified within distal CBD. No biliary dilation identified.

Oona Gallardo

Please Note: There may be substantive differences between a DRAFT and SIGNED Report

Signed REPORT

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intended recipient, you are hereby notified that any distribution or the taking of any action in reliance on or regarding the contents of this document is STRICTLY PROHIBITED. If you have received this document in error please notify the sender to arrange for return of the documents.

•

Riverside Medical Centre 4 Laboratory 115 Sherwood Blvd Nanaimo, Ontario T8X 0V9 Tel: (444) 426-4137

Ord: Gallardo, Oona Fam: NO PHYSICIAN Att: Oth: Date of OR:

Nguyen, Zola 579 Harlow Blvd Nanaimo, ON H1L 7N8 (919) 340-3971

REQ#: 0745 PHBA#: GD145786/89 UNIT#: Q897863084 DOB: 1996 AGE: 20 LOCN: R.ER

DATE OF EXAM: 16/09/2016 SPIE ABDOMINAL ULTRASOUND COMPLETE

Signed REPORT

AUTHENTICATED BY ELECTRONIC MEANS /PST 16/09/2016 Rep. # 0745 cc: Gallardo, Oona; NO PHYSICIAN

Please Note: There may be substantive differences between a DRAFT and SIGNED Report

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ACTION REQUIRED

Prescription Renewal Request

SKYRIZI

TO:	Dr. Pablo Dubois
FAX:	(749) 476-8640
DATE:	Aug 5, 2026
PATIENT:	Ms. Zola Nguyen
PATIENT ID:	PR733715
PATIENT DATE OF BIRTH:	MAR 16, 1996
PATIENT FILE NUMBER:	(blank)

Dear Dr. Dubois,

Please be advised that your patient requires a prescription renewal for the patient's pharmacy to continue dispensing SKYRIZI. In order for the prescription to be valid, kindly complete the "Dosage" and "Duration of treatment" sections below, then sign and date the form. **Once the required sections are complete, please fax the form back to (298) 271-3638.**

PRESCRIPTION RENEWAL

Patient: Ms. Zola Nguyen **Date of Birth:** MAR 16, 1996 **Diagnosis:** Crohn's Disease

Pharmacy: Westbrook Medical Associates

Pharmacy Fax #: (698) 469-8634

Dosage: ☒ 360 mg subcutaneously every 8 Weeks. ☐ Other dosage (specify): _____

Duration of treatment: ☒ 12 months ☐ 6 months ☐ 3 months ☐ Other (specify): _____

Physician Signature: _____ Date: _____

Physician Name: Dr. Pablo Dubois Bodhi Wilson

Address: 842 Larchmont Ave Nanaimo ON, A6G 3K2

Phone Number: (795) 884-5038 Fax Number: (749) 476-8640

Riverside Medical Centre 3 613-914-5839 9 AM to 5 PM, [REDACTED-DATE] through [REDACTED-PROVIDER-NAME]

www.ridgewayfamilyhealthsouth.ca

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MEMBER OF Brookfield Medical Centre 4

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Physician Name: Dr. Pablo Dubois Bodhi Wilson

Address: 842 Larchmont Ave Nanaimo ON, A6G 3K2

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Fax Cover Sheet

To: Sunnymede Family Practice 7 Phone: (712) 275-4756 Fax: (749) 476-8640

Date: 08/25/2026

From: Dr. Pablo Dubois Phone: (610) 219-1236 Fax: (692) 284-3928

Number of pages including cover: 2

Re: Dr. Rossi is not at this fax number

Special Note to Consultants:

We appreciate your involvement with our patients. In order to facilitate timely access to care, please send confirmation notice that referral requests have been received and accepted within 14 days of receiving the request. www.fairlightmedicalcentrewest.ca Your cooperation is greatly appreciated.

Confidential: This communication is intended only for the individual or institution to which it is addressed and should not be distributed, copied or disclosed to anyone else. The documents in this communication may contain personal, confidential or privileged information, which may be subject to the Freedom of information and Protection of Privacy Act, the Health Information Act and other legislation. If you have received this communication in error, please notify us immediately and return original transmission to us. Thank you for your co-operation and assistance.

Sunnymede Family Practice 7

876 Lakeview Blvd, Nanaimo, G3V 7D2 Tel: (712) 275-4756 Fax: (612) 374-3427

Dr. Lucia Ashby · Dr. Pablo Dubois · Dr. Ethan Marchand · Dr. Alma Bennett Dr. Esme Zhang · Dr. Zeynep Thibault · Dr. Anika Haddad

2026-Aug-18

Dear Dr. Diego Rossi

1996 7584113327VQ

Please fax over a new referral for patient Zola Nguyen

We are kindly requesting a brief note for a new referral so that we can continue to provide medically necessary comprehensive virtual care services. There is NO need to fill out our new patient referral form.

Our fax number is (612) 374-3427.

Note: As per the recent changes to Cedar Specialist Group 6 Schedule of Benefits, all patients will require a new referral every 24-months in order to be able to provide virtual care to our patients. Many patients find

virtual care much more convenient, and we would like to continue to offer this option to all our patients.

Thanks for your kind consideration and for allowing us to participate in the care of your patients.

Sincerely,

Pablo Dubois

Dr. Dubois Sunnymede Family Practice 7

Patient: Zola Nguyen PHN: 7584113327VQ DOB: 1996

Fax Number: 663-964-2399 Recipient: Dubois, Pablo

Birchwood Care Clinic 5 Radiology Tel: (496) 839-2065 MRI Appointment Notification

As of June 2016, MRI EXAMINATIONS WILL BE BOOKED 24 HOURS/DAY Please ensure patients are aware appointments can be booked during midnight hours. The appointment times below are state in military time(using the 24 hour clock). Please ensure all patients clearly understand whether their appointment is booked in the AM or PM.

Dubois, Pablo Fax: (749) 476-8640 Nanaimo Recipient: Fax Number:

The following patient have had appointments **Booked** in Community-Wide Scheduling between

Patient HCN Scheduled For Nguyen, Zola 2893386601-KJ 24 Sep 2026 15:15 **Appointment:** MRI Enterography 4 REP wGD 3D **Appointment Status:** Booked

All patients must arrive 45 minutes prior to appointment For registration and screening

Contact your patient with date and time of appointment IMMEDIATELY to minimize patient inquiries and No Shows **It is the most responsible physician's responsibility to notify the patient of their appointment date and time as per the CPSO guidelines Transitions in Care policy**

Patient Preparation For environmental reasons, General Medicine has stopped issuing plastic bags. We ask that you request patients bring their own reusable bag to hold their garments during their exam.

If your patient is claustrophobic, the physician is responsible for providing the patient with sedation and making the patient aware that they must bring a driver with them. We advise that the patient takes the sedation prior to arrival to ensure the patient is sedated for appointment.

Your patient will receive a phone confirmation approximately 1 week prior to their scheduled appointment **
END OF REPORT **