RECLAST INFUSION ORDER (ZOLEDRONIC ACID)

Date: ____/____/_____

PATIENT INFORMATION

Patient Name:_____ DOB:___/____/____ Phone: _____

Height: _____ Weight _____ lbs / kg

Allergies: _____

Diagnosis: _____ ICD-10: _____

Labs to be drawn by: O Infusion Clinic O Referring Physician

Hemoglobin result: _____ Date:_____

QUALIFIERS

O Hip or vertrebral fracture O Other prior fractures and T-score between 01.0 and -2.5

O T-score > or = to -2.5 O T-score between -1.0 and -2.5 WITH a 10 year probability of hip fracture risk

PRE-MEDICATIONS

Please indicate if needed:

RECLAST (ZOLEDRONIC ACID) IV DOSING

DOSE: O 5mg/100ml IV administered over 30 min X 1 Year

PROVIDER INFORMATION

Provider's Name: _____ Signature: _____

Phone: _____ Fax: _____ Date: _____/_____/_____

Office Address: _____

Email Address: _____ Contact Person: _____

PLEASE SEND COPY (FRONT AND BACK) OF INSURANCE CARD

PHONE: 972-810-0990 | FAX: 972-810-0994