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BY APPOINTMENT

# ZOLEDRONIC ACID (RECLAST) ORDER FORM

**LOCATION**

☐ Murray ☐ Tooele ☐ Layton

## REFERRAL STATUS

☐ New Referral ☐ Order Renewal

## PATIENT INFORMATION

| | | |
|---|---|---|
| PATIENT NAME: | | DOB: SEX: ☐ M: ☐ F: |
| WEIGHT: ☐ LBS ☐ KG | | PHONE #: |
| ALLERGIES: | | EMAIL: |
| Please check that the following are included: | ○ Patient demographics and insurance attached | ○ Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached |
| | ○ Current Medication List | |

## DIAGNOSIS

| | |
|---|---|
| ICD-10 CODE: M81.0 Osteoporosis Other: | Date of last infusion/injection: |

## PHYSICIAN INFORMATION

| | |
|---|---|
| Physician Name: | Phone Number: |
| Practice Name: | Fax Number: |
| Office Contact: | |

## MEDICATION ORDER

| Medication: | Dosing: | Frequency: | Notes/Comments |
|---|---|---|---|
| **Zoledronic Acid (Reclast)** | **5mg/100mL IV** | **Once Yearly** | |

Physician Signature ______________________ Date (Order is Valid for One Year) ________

## LAB ORDERS

☐ CMP ☐ CBC ☐ CRP ☐ ESR ☐ Other______________________________

☐ Labs to be Drawn by Infusion Center Frequency: ________ Standing Order? ☐ Yes ☐ No

## TYPE OF ACCESS

☐ Peripheral ☐ PICC ☐ Midline ☐ Port ☐ Subcu ☐ I/M