Infusion for Health
77 Rolling Oaks Drive, Suite 201
Thousand Oaks, CA 91361
Phone: 805-719-3700 Fax: 805-852-2636

Zoledronic Acid (RECLAST) ORDER

Please fax a copy of patient's demographics, insurance information, current lab results, H&P, and current medications, Dexa scan showing -2.5 or worse.

Date: ____/____/____

Patient Name: _____ DOB: _____/_____/_____

Allergies: _____ Wt: _____ lbs / kg Ht:_____

Diagnosis: _____ ICD 10: _____

Diagnosis made by: T-Score (Dexa) Please list WORST T-score & date: _____

History of fractures: Please list _____

Tried and failed bisphosphonates? Please list _____

Zoledronic Acid IV Dosage:

5 mg IV yearly X 1

Labs drawn on: ____/____/____ Serum Calcium: _____ Serum Creatinine: _____

Lab work required yearly.

Printed Provider's Name: _____ NPI: _____

Provider's Signature: _____ Date:_____/_____/_____

Office phone number: _____ Office Fax:_____

Office address: _____Contact person: _____