Zoledronic Acid Order
(Reclast)

INFUSION FOR HEALTH

Ph: 805-719-3700 | Fax: 805-852-2636

Date: ___/___/___ Treatment Location: _____

***Please fax a copy of the following patient information:** ☐ Demographics ☐ Insurance Information ☐ Current Lab Results ☐ H & P ☐ Current Medications ☐ Dexa Scan

PATIENT INFORMATION

Patient Name: _____

DOB: ___/___/___

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ___/___/___

Phone: (___) ___-____ Fax: (___) ___-____

Office Address: _____

Contact Person: _____

DIAGNOSIS:

Diagnosis made by: T-Score (Dexas) 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.