

Zoledronic Acid infusion orders

Patient Name _____ DOB _____

Phone _____ M F

DIAGNOSIS *Please provide ICD-10 code*

- _____ Osteoporosis _____ Other
- _____ Senile Osteoporosis
- _____ Paget's Disease of the Bone
- _____ Glucocorticoid-induced Osteoporosis

PRE-MEDICATION

- Tylenol 1000mg PO Solu-Medrol 125mg IVP
- Diphenhydramine 25mg PO Solu-Cortef 100mg IVP
- Cetirizine 10mg PO Diphenhydramine 25mg IVP
- _____ _____
- Length of Need _____

ZOLEDRONIC ACID ORDERS

DOSAGE

_____ mg

FREQUENCY

- every _____ weeks
- every _____ years

PATIENT WEIGHT

_____ lbs.

_____ kg

Refills: _____

TESTING/LABS

- Creatinine Lab
- Calcium Level

Notes

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Address _____

NPI# _____

DEA# _____

FAX ORDERS: 702-780-4887