Fax: 614-929-7199/ Phone: 614-929-3349/ Email: Info@infuseoneohio.com

INFUSE ONE

Zoledronic Acid infusion orders

Patient Name _____ DOB _____

Phone _____ M ☐ F ☐

DIAGNOSIS *Please provide ICD-10 code*

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

PRE-MEDICATION

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

ZOLEDRONIC ACID ORDERS

DOSAGE

☐ _____ mg

FREQUENCY

☐ every _____ weeks

☐ every _____ years

PATIENT WEIGHT

_____ lbs.

_____ kg

TESTING/LABS

- ☐ Creatinine Lab
- ☐ Calcium Level

NOTES

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____

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