

Zoledronic Acid

PATIENT INFORMATIONReferral Status (check one): New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____

NKDA Allergies: _____ Weight _____ Please specify: lbs kg Height: _____Patient Status (check one): New to Therapy Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION**DIAGNOSIS**

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

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

- Dose: _____ mg
- Frequency: every _____ months
 every _____ weeks
- Infuse over 60 minutes

PATIENT WEIGHT____ lbs.
____ kg**SPECIAL INSTRUCTIONS****PROVIDER INFORMATION**

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Provider Name (Print)_____
Provider Signature_____
Date