Email: intake@infuseoneohio.com | Phone: 614-929-3349 | Fax: 614-929-7199

INFUSE ONE OHIO

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

Provider NPI: _____ Phone_____ Fax _____

Provider Name _____

Provider Address _____

Signature _____ Date_____