adaptIV infusion

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 _____

Please fax order form along with patient insurance information to: 832-895-4040
Questions? Email us at intake@adaptivinfusion.com