Infusion Center
1500 Associates Drive • Dubuque, IA 52002
563-584-4370

RECLAST (zoledronic acid) ORDER FORM

Prerequisites to treatment – ensure the following information is complete and attached with referral: ☐ Demographics ☐ Prior Authorization ☐ Office/Progress Notes

PATIENT INFORMATION

Patient Name: ______________________________ D.O.B.____________ ☐ Male ☐ Female

Phone Number: ______________________________ Allergies: ______________________________

DIAGNOSIS

☐ Osteoporosis ICD 10: ___________________

☐ Other: ____________________________________ ICD 10: ___________________

PRE-MEDICATION

☐ Tylenol 1000mg PO ☐ Other: ______________________________

MEDICATION

Reclast

Dosing: ☐ IV 5mg/100mL

Duration: ☐ Infuse over 15-20 minutes OR ☐ Infuse over __________ minutes.

Frequency: ☐ Yearly

Route: ☐ Peripheral IV per protocol ☐ PICC capping per protocol ☐ PORT capping per protocol

☐ Monitor vitals baseline and post infusion

☐ Other: ____

☐ New Start ☐ Continuation ☐ Date of last dose (if applicable) _______________

LABS MANAGEMENT: Any necessary labs will be ordered, reviewed, and managed by the referring provider prior to sending an Infusion Center order. Infusion staff will assume that it is acceptable to proceed with medication administration once Infusion Center order is received.

REFERRING PROVIDER INFORMATION

For questions regarding patient's care during the infusion, please contact:

Facility: ______________________________ Fax: ________________

Name 1st Point of Contact (must be available during infusion): ______________________

Phone: ______________________

Name 2nd Point of Contact (must be available during infusion): ______________________

Phone: ______________________

By referring to the Medical Associates Infusion Clinic, it is recognized and agreed upon that the referring specialist or delegate listed above will be available and responsive during the duration of the scheduled infusion appointment. This contact should be available to answer any questions and/or address concerns related to the care of the patient. The on-site provider within the Infusion Clinic will be responsible for urgent patient care needs during the infusion.

Ordering Provider Name (please print): ______________________________

Ordering Provider Signature: ________________________ Date: ____________

FAX NUMBER: 563-584-4232 **PHONE NUMBER**: 563-584-4370

Order valid for 1 year from date of signature unless otherwise specified.