



RECLAST

(zoledronic acid)

PATIENT DEMOGRAPHICS

Patient Name:

Date of Birth: _____ M: F: Address: _____

Phone: _____ City, State, Zip: _____

Email: _____

Allergies:

PRIMARY DIAGNOSIS

ICD-10 Code:

DOCUMENTATION (PLEASE ATTACH)

Clinical / Progress Notes, Labs, Tests supporting primary diagnosis

- Serum creatinine level and date (attach results)
- Serum calcium level and date (attach results)

Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

PRE-MEDICATION

- | | |
|--|---|
| <input type="checkbox"/> Acetaminophen 1000mg PO | <input type="checkbox"/> Solu-Medrol 125mg IVP |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Solu-Cortef 100mg IVP |
| <input type="checkbox"/> Ceterizine 10mg PO | <input type="checkbox"/> Diphenhydramine 25mg IVP |
| <input type="checkbox"/> Loratadine 10mg PO | <input type="checkbox"/> Other: _____ |

PRIMARY MEDICATION ORDER

Dosage

- 5mg/100ml

Patient Weight:

lbs

Frequency

- Once yearly

kg

NOTES

ORDERING PROVIDER

Provider Name: _____

NPI: _____

Practice Name: _____

Phone: _____

Office Contact: _____

Fax: _____

Practice Address: _____

City, State, Zip: _____

Provider Signature: _____

Date: _____