Houssam Al Kharrat
Gastroenterology

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RECLAST (zoledronic acid) Infusion orders

Name:________________________ DOB:__________________ M ◯ F ◯

Phone #1 :____________________(H/W/C) Phone #2:_____________________(H/W/C)

Please include:

- ☐ Bone Density Report
- Recent Lab Report (within the last three months):
  - ☐ Creatinine clearance (greater or equal to 35 mL/minute)
  - ☐ Serum calcium level

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ ____________________ *(other)*

DIAGNOSIS *Please provide ICD-10 code*

- ☐ __________ Age-related osteoporosis ***without*** current pathological fracture
- ☐ __________ Age-related osteoporosis ***with*** current pathological fracture
- ☐ __________ Cancer treatment-induced bone loss due to hormone ablation therapy (CTIBL-HALT)
- ☐ __________ ______________________________ *(other)*

RECLAST ORDERS

Administer Reclast (zoledronic acid) 5 mg/100ml,
IVPB over no less than 15 minutes one time per year

PATIENT WEIGHT
___________ lbs.
___________ kg

NOTES

ORDERING PROVIDER

Signature X____________________________________ Date_____________________________

Provider _________________________ Phone ____________________ Fax_______________________

Please FAX: ◯ Medication Order ◯ Demographics ◯ Clinicals ◯ Labs ◯ X-Rays
◯ Front and back of insurance card
to 1-806-302-1241