Ambulatory Infusion Center

Parkway Medical Center
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Beachwood, OH 44122

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www.idconsultants.com/aic

INFUSION ORDERS – RECLAST (zoledronic acid)

Date of Referral: ___________________ Infusion Location: ☐ Beachwood ☐ Middleburg Heights

Patient Information

Patient Name: ____ Date of Birth: ________________________________

Address: ____

City: ______________________________________ State: ____________________ Zip Code: ___________________

Phone: _______________________________________ WT (kg): ________________ HT (in): ___________________

Diagnosis: ___________________________________ ICD10 Code: ____

Allergies: ____

PLEASE FAX SUPPORTING CLINICAL DOCUMENTATION, INCLUDING MEDICAL RECORDS/PROGRESS NOTES, LABS, and INSURANCE INFORMATION (both front and back of the card) ALONG WITH THIS FORM

RECLAST DOSING

☐ 5 mg/100 ml IV over no less than 15 minutes

☐ Special Needs/Considerations: ____

☐ Creatinine (within 30 days before administration, CrCl must be > 35 ml/min)

Date of last serum creatinine: _____________________________ Result: ______________________mg/dL

Prescribing Physician: ____

Address: ____

Physician Signature: ____ Date: ______________________________

Physician Phone: ____________________________________ Fax: ____

LAB REQUIREMENTS and LAB MONITORING ARE THE RESPONSIBILITY OF THE PRESCRIBING PHYSICIANS