Zoledronic Acid Infusion Order

Fax 281-715-5302 Phone 281-265-0100

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

◯ M85.80 Other disorder of bone density and structure; osteopenia with the risk of fracture; unspecifed site

◯ M81.0 Age related osteoporosis without pathological fracture

◯ Other _____

ICD-10 _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ALSO INCLUDE...

◯ Clinical/ Progress Notes

◯ Demographics Sheet

◯ Current Medications

◯ Labs

ZOLEDRONIC ACID ORDER

Zoledronic Acid Dose: ◯ 5mg IV

Frequency: ◯ Every _____ year (s)

Patient is currently taking Calcium/Vitamin D Supplement ◯ YES ◯ NO

Date of last Zoledronic Acid Infusion: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____