Phone:616-954-0600 Fax: 616-954-1675

Reclast IV Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: ____ **DOB**: _____/_____/_____

Allergies: ______________________________ **Patient Weight:** _________lbs / kg **Height:**____________

Diagnosis : ☐ Osteoporosis, please specify ICD-10 code: ____________________________________
☐ Other: please specify:____

Attach most recent DEXA scan results: Date:_________________________ T-Score: ____________________

In the past year, what medications for the above diagnosis has the patient tried and failed?
☐ N/A continuation of treatment

Drug	Dose	Dates of use

Reclast (Zoledronic Acid) **5 mg IV infusion**
Yearly for a total of 1 dose per year

Labs required within 3 months of appointment.
Result date: ____/_____/____

Serum Calcium: ______________

Serum Creatinine: _____________

Contraindicated in patients with Hypocalcemia or creatinine clearance <35mL/min

Printed provider name: ____

Provider signature: ____

Office phone number: _____________________ **Fax number:** ___________________________________