CURBSIDE INFUSION SERVICES

Fax To: 281-406-1047
Email To: referrals@curbsideinfusion.com
Office: 281-406-1046

Zoledronic Acid infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Osteoporosis
- ☐ _____ Senile Osteoporosis
- ☐ _____ Paget's Disease of the Bone
- ☐ _____ Glucocorticoid-induced Osteoporosis
- ☐ _____ Other

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ Quzyttir 10mg IVSP over 1-2 min
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____

ZOLEDRONIC ACID ORDERS

DOSAGE

_____ mg

FREQUENCY

- ○ every 1 year for 1 day
- ○ other: _____

PATIENT WEIGHT

_____ lbs.

_____ kg

TESTING/LABS

- ☐ Creatinine Lab
- ☐ Calcium Level

NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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