

Name: _____
MRN: _____
DOB: _____

Today's Date _____ Time _____

Diagnosis: _____ Other: _____

Age: _____ Height (cm): _____ Weight (kg): _____ BSA (m²): _____

ALLERGIES/Sensitivities: NKDA or _____

Start Date (at least 1 wk from today): _____ **Urgent (Call Infusion Center)**

Treatment Department: EHW OP Infusion

Appointment Requests: Tolerance: Use default, for chronic treatments order valid for 1 year

Appointment Request – Infusion – 1 hour Every 365 days

Treatment Conditions (Administer Treatment If): Once on Day 1
 Order will be done as per appointment frequency

Estimated Glomerular Filtration Rate (eGFR) GREATER THAN OR EQUAL TO 35 mL/min (within 30 days)

Corrected Calcium GREATER THAN OR EQUAL TO 8.3 mg/dL (within 30 days)

Note: corrected calcium = $[(0.8 \times (4 - \text{Patient's Albumin})) + \text{Serum Calcium}]$

Patients should not have invasive dental procedures (i.e. direct bone injury, placement of implants, etc.) (within +/- 2 months of Zoledronic Acid)

Okay to treat. Include details here: _____

Labs: Lab (if selected) will be done as per appointment frequency selected above (unless specified)

Comprehensive Metabolic Panel Once on Day 1

Provider Communication: Order will be done as per appointment frequency

Consider obtaining baseline dental exam and then every 6 months while on zoledronic acid. If using for osteoporosis or Paget's disease, do not dose more than once each year

Nursing Orders: Order will be done as per appointment frequency

Please note that this applies only if BMA (zoledronic acid or denosumab) is ordered:

Confirm that patient is taking Calcium 1200-1500 mg/day (in divided doses) and Vitamin D 800-1000 IU / day if treating for Paget's Disease.

If for osteoporosis, these supplements recommended if dietary intake inadequate

All information provided on this form & calculations have been independently confirmed & recalculated as indicated by signature(s) below

Licensed Medical Professional

Print Name: _____

Signature _____

Date _____

Contact # _____

Attending Physician

Print Name: _____

Signature _____

Date _____

Contact # _____

Name: _____
MRN: _____
DOB: _____

Supportive Care:

Order will be done as per appointment frequency

- Sodium chloride 0.9% prime bag 250 ml
250 ml, intravenous, at 0-999, PRN as needed, Prime Bag

Medications:

Order will be done as per appointment frequency

- zoledronic acid (Reclast®) IVPB 5 mg, intravenous, Administer over: 20 Minutes, Once

Emergency Medications

Order will be done as per appointment frequency

- Hypersensitivity reaction protocol

Protocol Document: <https://emory.ellucid.com/documents/view/15307/15641>

All information provided on this form & calculations have been independently confirmed & recalculated as indicated by signature(s) below

Licensed Medical Professional

Print Name: _____
Signature _____
Date _____
Contact # _____

Attending Physician

Print Name: _____
Signature _____
Date _____
Contact # _____