Patient Name: _____

Address: _____

Phone Number: _____ Date of Birth: _____ Age: _____ Weight: _____ KG

Diagnosis: ☐ Postmenopausal osteoporosis 733.01 CPT 96365 + pharmacy fee for drug

Allergies: _____

Physician's office fax #: _____

Fax to: Overlake Hospital Centralized Scheduling Center
Fax: (425) 688 – 5710
Phone: (425) 688 – 5700
Infusion Suite: (425) 688 – 3773 Third Floor, West Tower

Patient reports to admission desk in Overlake Hospital lobby

Date infusion is scheduled: _____ Time scheduled: _____

INFORMATION TO ACCOMPANY THIS ORDER:

- Primary and Secondary insurance information. Please copy front and back of card and fax along with this form.

If unable to copy, please provide insurance name, phone number and policy #, group # and policy holder name

_____

_____

- Authorization from insurance company

If no authorization is required, please explain: _____

_____

- Serum Creatinine lab results
- Copy of recent H & P including list of medications

PRE-SCREENING SAFETY ISSUES:

- Serum creatinine must be normal
- Zoledronic Acid (Reclast) will NOT be given if creatinine clearance measured or estimated GFR less than or equal to 35 mL/ minute
- Patient must be taking calcium and vitamin D supplements
- Labs must be done prior to IV administration (send with this order)

MEDICATIONS:

Zoledronic Acid (Reclast) 5 mg in 100 mL IV over 20 minutes X 1 (Code J 3488)	Osteoporosis
Acetaminophen 325 mg PO X 1	Infusion Reaction

_____ _____ _____

Physician Signature Date Time

P H Y S I C I A N O R D E R

OVERLAKE Hospital Medical Center
Medical excellence every day™

RECLAST INFUSION SUITE REFERRAL ORDERS
P0240A (Rev 0709) White – Chart