



Clearwater: Phone: 727.977.9717 | Fax: 727.977.9717
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(zoledronic acid)

RECLAST injection orders

Patient Name _____ DOB _____

Phone _____ M O F O

DIAGNOSIS Please provide ICD-10 code

- _____ Age-related osteoporosis **without** current pathological fracture
- _____ Age-related osteoporosis **with** current pathological fracture
- _____ Other osteoporosis without current pathological fracture
- _____
(Other osteoporosis current pathological fracture)

PRE-MEDICATION

- Tylenol 1000mg PO
- Diphenhydramine 25mg PO
- Cetirizine 10mg PO
- _____
(other)

PROLIA ORDERS

<p>DOSAGE</p> <p><input checked="" type="radio"/> 5mg IV, every year</p> <p>_____ Last Reclast infusion date (if applicable)</p>	<p>PATIENT WEIGHT</p> <p>_____ lbs.</p> <p>_____ kg</p>
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NOTES

ORDERING PROVIDER

Signature X _____ Date _____