THE UNIVERSITY OF KANSAS HOSPITAL
3901 Rainbow Boulevard
Kansas City, Kansas 66160

PHYSICIAN'S ORDER FORM

Do not write in this box

PATIENT LABEL

DATE & TIME	#	ORDERS **IBANDRONATE SODIUM (BONIVA®)**
		Reference: www.boniva.com accessed 3/25/2009.
	1.	Attending Physician:_____ Pager:_____ Resident Physician:_____ Pager:_____
	2.	**Diagnosis:** **ICD-9 Code:** ☐ **733.01 (post menopausal osteoporosis)** ☐ **733.02 (Idiopathic osteoporosis)** ☐ **733.09 (steroid induced osteoporosis)** ☐ **733.00 (male osteoporosis)**
	3.	**Allergies:** **Patient weight: _____kg**
	4.	**Labs** to be drawn prior to infusion:
	5.	**Nursing:** • Obtain patient's VS prior to the infusion • Confirm eGFR is ≥ 30 mL/min • Confirm serum calcium is within normal range • Insert saline lock
	6.	**IV Fluids:** • Flush IV site with 10mL NS prior to and at the completion of the infusion.
	7.	**Medications:** • Intravenous ibandronate sodium (Boniva®) 3mg IV push over 60 seconds every 3 months.
	8.	DC IV and discharge to home.

Physician Signature: _____ Pager: _____

IBANDRONATE SODIUM (BONIVA®) **(Page 1 of 1)**