THE UNIVERSITY OF KANSAS HOSPITAL 3901 Rainbow Boulevard Kansas City, Kansas 66160 PHYSICIAN'S ORDER FORM	Do not write in this box DT0017	PATIENT LABEL

DATE & TIME	#	ORDERS ZOLEDRONIC ACID (RECLAST®) (For outpatient use only)
		Reference: www.reclast.com accessed 3/25/2009.
	1.	Attending Physician:_____ Pager:_____ Resident Physician:_____ Pager:_____
	2.	**Order Initiation date**: *(Expires 6 months from initiation date)*
	3.	**Diagnosis:** **ICD-9 Code:** ☐ **733.01 (post menopausal osteoporosis)** ☐ **731.0 (Paget's disease of the bone)** ☐ **733.00 (male osteoporosis)** ☐ **733.09 (Steroid induced osteoporosis)** ☐ **Other:_____ (ICD-9_____)**
	4.	**Allergies:** _____ **Patient weight:** _____**kg**
	5.	**Labs** to be drawn prior to infusion:
	6.	**Nursing:** • Obtain patient's VS prior to and at the end of the infusion • Confirm eGFR is ≥ 30 mL/min • Confirm serum calcium is 9-11 mg/dL • Confirm patient has had at least 2 glasses of liquid within a few hours prior to infusion • Confirm patient is not also taking zoledronic acid (Zometa®) • Insert saline lock • If unable to confirm, hold infusion and notify physician
	7.	**IV Fluids:** • Flush IV site with 10mL NS prior to and at the completion of the infusion.
	8.	**Medications:** • Intravenous zoledronic acid 5 mg IV over at least 15 minutes. • Infuse over no less than 15 minutes • Ensure medication is given at room temperature using vented tubing packaged with the medication
	9.	DC IV and discharge to home.

Physician Signature: _____ Pager: _____ Date:_____ Time:_____

ZOLEDRONIC ACID (RECLAST®) **(Page 1 of 1)**