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®)**
		Reference: www.reclast.com accessed 3/25/2009.
	1.	Attending Physician:_____ Pager:_____ Resident Physician:_____ Pager:_____
	2.	**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)** ☐ **733.90 (Osteopenia)** ☐ **Other:**_____
	3.	**Allergies:** _____ **Patient weight:** _____**kg**
	4.	**Labs** to be drawn prior to infusion:
	5.	**Nursing:** • Obtain patient's VS prior to and at the end of the infusion • Confirm eGFR is ≥ 30 mL/min • Confirm serum calcium is within normal range • 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
	6.	**IV Fluids:** • Flush IV site with 10mL NS prior to and at the completion of the infusion.
	7.	**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
	8.	DC IV and discharge to home.

Physician Signature: _____ Pager: _____

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