

Zoledronic Acid Referral Form



Patient Preferred Clinic (select one):

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

DOB:	Patient Name:	Patient Phone:	
Patient Address:	Patient Email:		
NKDA Allergies:	Weight (lbs/kg):	Height:	
ICD-10 code (required):	ICD-10 description:	Last Treatment Date:	Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

CBC at each dose every _____
 CMP at each dose every _____
 CRP at each dose every _____
OTHER _____

PREMEDICATIONS

acetaminophen (Tylenol) 500 mg 650 mg 1000 mg PO
cetirizine (Zyrtec) 10mg PO
loratadine (Claritin) 10mg PO
diphenhydramine (Benadryl) 25 mg 50 mg PO IV
methylprednisolone (Solu-Medrol) 40mg 125mg IV
hydrocortisone (Solu-Cortef) 100mg IV
Other: _____
Dose: _____ Route: _____

ZOLEDRONIC ACID THERAPY ADMINISTRATION

5 mg IV every one year
 5 mg IV every 2 years
Other: _____

REQUIRED DOCUMENTATION

- Patient Demographics
- Insurance Card/Information
- Progress Notes Supporting DX
- Medication List and H&P
- DEXA Results
- Creatinine within 12 months

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print)	Provider Signature	Date
-----------------------	--------------------	------

Fax Numbers			Have a Question? (720) 902-4111 Email Referrals To: referrals@vivoinfusion.com Email Specialty Referrals to: info@specialtyinfusion.com
Virginia: 804-500-5941	Nevada: 702-489-5744	Massachusetts: 800-540-1852	
Colorado: 303-418-4679	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244	
Florida: 904-930-4211	Ohio: 216-400-0674	New York: 800-540-1852	
Texas: 469-340-0044	Oklahoma: 918-770-4421	Connecticut: 203-724-4838	