



Patient Name _____
DOB _____
MRN _____
Physician _____
FIN _____

Defaults for orders not otherwise specified below:

- Once
- Interval: Every 365 days

Duration:

- 1 Treatment
- Until date: _____
- 1 year

Anticipated Infusion Date _____ ICD 10 Code with Description _____

Height _____ (cm) Weight _____ (kg) Allergies _____

Site of Service

- SH Gerber
- SH Lemmen Holton (GR)
- SH Pennock
- SH United Memorial
- SH Helen DeVos (GR)
- SH Ludington
- SH Reed City
- SH Zeeland

Provider Specialty

- Allergy/Immunology
- Infectious Disease
- OB/GYN
- Rheumatology
- Cardiology
- Internal Med/Family Practice
- Other
- Surgery
- Gastroenterology
- Nephrology
- Otolaryngology
- Urology
- Genetics
- Neurology
- Pulmonary
- Wound Care

Appointment Requests

- Infusion Appointment Request**
Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion and possible labs

Safety Parameters and Special Instructions

- ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 4**
ZOLEDRONIC ACID :

Acetaminophen after the infusion may reduce symptoms of acute-phase reactions.

Patients with osteoporosis should receive calcium and vitamin D supplementation if dietary intake is inadequate.

Prior to each dose, obtain serum creatinine and calculate the creatinine clearance using the Cockcroft-Gault formula.

Zoledronic acid is not recommended for patients with severe renal impairment. Longer infusions may reduce risk of nephrotoxicity.

Labs

	Interval	Duration
<input checked="" type="checkbox"/> Comprehensive Metabolic Panel (CMP) Status: Future, Expected: S, Expires: S+184, URGENT, Clinic Collect, Blood, Blood, Venous		
<input checked="" type="checkbox"/> Calcium, Blood Level, Total Status: Future, Expected: S, Expires: S+365, STAT, Clinic Collect, Blood, Blood, Venous		
<input checked="" type="checkbox"/> Magnesium, Blood Level Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous		
<input checked="" type="checkbox"/> Phosphorus, Blood Level Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous		

- Lab: _____
- Every ___ days
- Until date: _____
- Once
- 1 year
- # of Treatments

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NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.



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Treatment Parameters

- ONC MONITORING AND HOLD PARAMETERS 15**
Hold treatment and contact provider if serum creatinine greater than 2 mg/dL
- ONC MONITORING AND HOLD PARAMETERS 14**
Hold treatment and contact provider if creatinine clearance (CRCL) less than 35 mL/minute. Zoledronic acid (RECLAST) is contraindicated in patients with creatinine clearance less than 35 mL/min and in those with evidence of acute renal impairment.
- ONC MONITORING AND HOLD PARAMETERS 3**
May proceed with treatment if patient does not report any symptoms of jaw or dental pain.

Nursing Orders

- ONC NURSING COMMUNICATION 10**
ZOLEDRONIC ACID:
Infuse over at least 15 minutes. Flush IV line with 10 mL NS flush following infusion. Infuse in a line separate from other medications. Patients must be appropriately hydrated prior to treatment. Acetaminophen after administration may reduce the incidence of acute reaction (eg, arthralgia, fever, flu-like symptoms, myalgia).
- ONC NURSING COMMUNICATION 100**
May Initiate IV Catheter Patency Adult Protocol

Medications

- zoledronic acid (RECLAST) IVPB premix 5 mg**
5 mg, Intravenous, Administer over 30 Minutes, Once, Starting S, For 1 Dose
Flush IV line with 10 mL NS flush following infusion. Infuse in a line separate from other medications.

Supportive Care

- acetaminophen (TYLENOL) tablet 650 mg**
650 mg, Oral, Once PRN, Other, As needed to reduce the incidence of acute reaction, Starting S, For 1 Dose
Acetaminophen after the infusion may reduce the incidence of acute reaction (eg, arthralgia, fever, flu-like symptoms, myalgia).



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Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED:		VALIDATED:		ORDERED:		
TIME	DATE	TIME	DATE	TIME	DATE	Pager #
	Sign		R.N. Sign		Physician Print	Physician