# Zoledronic Acid Infusion Order

LivWell INFUSIONS

*Fax 888 511-7654* *Phone 888 864-7341*

**Patient Name:** _____ **DOB:** _____

**Patient Phone:** _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

## MEDICAL INFORMATION

**Diagnosis:**

◯ M85.80 Other disorder of bone density and structure; osteopenia with the risk of fracture; unspecifed site

◯ M81.0 Age related osteoporosis without pathological fracture

◯ Other _____

**ICD-10** _____

**ALSO INCLUDE...**

- Clinical/ Progress Notes
- Insurance
- Demographics Sheet
- Current Medications
- Labs

## ZOLEDRONIC ACID ORDER

**Zoledronic Acid Dose/Frequency:** ◯ 5mg IV every 1 year

**Other Frequency:** ◯ 5mg every _____ year

**Patient is currently taking Calcium/Vitamin D Supplement** ◯ YES ◯ NO

**Date of last Zoledronic Acid Infusion:** _____

**Additional Comments:**

## PHYSICIAN INFORMATION

**Referring Physician:** _____ **Phone:** _____

**Practice Address:** _____

**Office Contact:** _____ **Fax:** _____

**NPI/ TIN:** _____

**Referring Physician's Signature**_____ **Date:** _____