Atrium Health Infusion Centers
Phone: 704-468-3400 **Fax:** 704-468-3401

Reclast Infusion Order (Revised 4/3/21)

Instructions to Provider: Please fax completed order, along with referral form to desired location.

Required Lab Results: Calcium and Creatinine within 3 months of infusion (If outside Atrium, please fax with order. Required prior to scheduling.)

Infusion Therapy:

☐ Reclast (zoledronic acid) **5** mg IV over 15 minutes

Frequency: yearly

ICD 10 code: _____

Pre-Meds:

☐ Acetaminophen 1000 mg PO x 1 (unless taken at home)

Additional Orders:

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Special Instructions:

- No recent implants, root canals, or invasive dental work.
- Follow Atrium Health Infusion Center protocol for hypersensitivity reaction PRN.
- Notify provider if creatinine clearance is less than 35mL/min

Infusion Monitoring:

- Obtain vital signs pre- and post-infusion. Obtain vital signs during the infusion PRN.
- Monitor patient for 30 minutes after completion of 1st infusion and subsequent infusions PRN if previous signs of reaction noted.

Provider Name: ___________________________________

Provider Signature: ________________________________

Date: _________ (Order valid for 1 year)

Patient Name:

DOB:

MRN:

Provider Name: ___________________________________

Provider Signature: ________________________________

Date: _________ (Order valid for 1 year)

Patient Name:

DOB:

MRN: