



Infusion Associates
 3230 Eagle Park NE, Suite 101
 Grand Rapids, MI 49525
 Phone: 616-954-0600 Fax: 616-954-1675

Reclast Infusion
J-Code-J3489

**Please fax a copy of patient's Demographics, Insurance information, Current Lab Results, H&P, and Current Medications*

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Allergies: _____ Patient Weight: _____ lbs / kg Height: _____

History of recent tooth extraction or jaw surgery: No Yes

History of renal disease: No Yes

Diagnosis : Age related osteoporosis without current pathologic fracture M 81.0
 Other osteoporosis without current pathologic fracture (idiopathic) M 81.8
 Other: please specify: _____

Diagnosis made by : T-Score (Dexa) FRAX model Other risk factors: _____

Reclast (Zoledronic Acid) 5 mg IV yearly x 1

Lab work required within 2 months of appointment.

Labs drawn on: ____/____/____

Serum Calcium: _____

Serum Creatinine: _____

Contraindicated in patients with Hypocalcemia or creatinine clearance <35mL/min

Printed Provider's Name: _____

Provider Signature: _____

Office Phone Number: _____ Office Fax Number: _____