MIC METRO INFUSION CENTER

Goserelin (Zoladex)

Name:
DOB:
Diagnosis/Code: /
Cancer Stage:

Dose calculation:
Flat dose, not a weight based medication

Dosing Guidelines/Parameters: ***Provider must select hold parameters that will trigger a call from the Infusion Staff***

Hydration Orders:
Not required
Other:

Premedication and Antiemetic Orders:
Not required
List any numbing procedure prior to injection if any:

Treatment Orders:

DRUG	DOSE	ROUTE	DAYS TO BE GIVEN
☐ Goserelin (Zoladex)	3.6 mg*	SQ implanted spring loaded injection	Every 4 weeks
☐ Goserelin (Zoladex)	10.8mg *	SQ implanted spring loaded injection	Every 12 weeks
☐ Goserelin (zoladex)		SQ implanted spring loaded injection	

***See instructions on how to administer in the abdomen only**

Date of intended first treatment at Metro Infusion Center:_____
Subsequent treatment may be given +/- 2 days or as otherwise specified:
This order is good for 1 year from the date ordered

Other:

Call referring provider for:

Other reasons to call:

Date:

Referring Provider:_____ _____ Phone# _____
SIGNATURE REQUIRED PRINTED NAME REQUIRED

Office Contact name/number:

All information in this order is strictly confidential and will become part of the patient's medical record. Contact us with questions at (877)448-3627. Send completed form and all documentation to confidential email: Intake@metroinfusioncenter.com or fax to (866)507-1164

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