



METRO INFUSION CENTER

Name: _____

DOB: _____

Diagnosis/Code: _____ / _____

Cancer Stage: _____

Goserelin (Zoladex)

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
<input type="checkbox"/> Goserelin (Zoladex)	3.6 mg*	SQ implanted spring loaded injection	Every 4 weeks
<input type="checkbox"/> Goserelin (Zoladex)	10.8mg *	SQ implanted spring loaded injection	Every 12 weeks
<input type="checkbox"/> 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:

MICreferral@metroinfusioncenter.com or fax to (866)507-1164

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