



METRO INFUSION CENTER

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

Zoledronic Acid (Zometa)

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*

- Dental clearance done (send clearance or note that outlines no dental issues)
- Creatinine clearance-based dosing (Referring office will get labs prior to each infusion and send labs to MIC **with creatinine clearance** listed to determine dosing)
- Calcium WNL

Hydration Orders:

- Not required
- Other: _____

Premedication Orders:

Treatment Orders:

DRUG	DOSE	ROUTE	DAYS TO BE GIVEN
<input type="checkbox"/> Zoledronic Acid (Zometa)	4mg* Creatinine Clearance >60	IVPB	Every 4 weeks Every 3 months Every _____
<input type="checkbox"/> Zoledronic Acid (Zometa)	3.5mg* Creatinine Clearance 50-60	IVPB	Every 4 weeks Every 3 months Every _____
<input type="checkbox"/> Zoledronic Acid (Zometa)	3.3mg* Creatinine Clearance 40-49	IVPB	Every 4 weeks Every 3 months Every _____
<input type="checkbox"/> Zoledronic Acid (Zometa)	3mg* Creatinine Clearance 30-39	IVPB	Every 4 weeks Every 3 months Every _____

***Provider to send new order if Creatinine Clearance changes from original order.**

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: _____

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