

(Reclast)

Provider Order Form rev. 2/28/23



14107 Cortez Blvd
Brooksville FL 34613
P: (352)549-9962
F: (352)549-9963
www.360infusioncenter.com
E: info@360infusioncenter.com

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____

ICD-10 code (required): _____ ICD-10 description: _____

NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

NURSING

0 TB status & date (list results here & attach clinicals)

0 Provide nursing care per 360 Infusion Center Nursing Procedures, including reaction management and post-procedure observation

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- CRP at each dose every _____
- Other: _____

PRE-MEDICATION ORDERS

- acetaminophen (Tylenol) 500mg / 650mg / 1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl) 25mg / 50mg PO / IV
- methylprednisolone (Solu-Medrol) 40mg / 125mg IV
- hydrocortisone (Solu-Cortef) 100mg IV
- Other: _____
Dose: _____ Route: _____
Frequency: _____

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

- (Reclast) injection
 - Dose: 5mg Other
 - Frequency: Every 12 months other
 other: _____
 - Route: 0 subcutaneous
- Patient is required to stay for 30-minute observation
- Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

Provider Name
(Print)

Provider Signature

Date