



Infusion Center

Kennebunk • Portsmouth • Scarborough • Topsham

Phone: 207-303-3225 Fax:207-692-2473

### Pamidronate Order Form

<b>Patient Name:</b> _____	<b>DOB:</b> _____
<b>Diagnosis:</b> _____	<b>Diagnosis Code:</b> _____
<b>Height:</b> _____(cm)	<b>Actual Weight:</b> _____(kg)
<b>Allergies:</b> _____	

**Please list any premeds needed here:** \_\_\_\_\_

**Pamidronate:**  30mg  60mg  90mg  Other \_\_\_\_\_mg.

**Frequency:** \_\_\_\_\_.

**Infusion rate will be over 2 hours unless otherwise specified.**

**Other specified rate:** \_\_\_\_\_.

**\*CMP labs will be required prior to each infusion unless given on consecutive days\***

**\* In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.**

<b>Provider Name:</b> _____
<b>Provider Signature:</b> _____ <b>Date:</b> _____
<b>Phone:</b> _____ <b>Fax:</b> _____ <b>Pager:</b> _____