Mankato Clinic
Together we thrive.

ADULT AMBULATORY INFUSION ORDER

Ibandronate sodium (BONIVA) Injection

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Date: _____/_____/_____

***Please fax a copy of the following patient information:** ☐ Demographics ☐ Insurance Information ☐ Current Lab Results ☐ H & P Relevant to Diagnosis ☐ Last infusion note ☐ Current Medications

PATIENT INFORMATION

Allergies: _____

Weight: _____ lbs/kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ____/_____/_____

Phone: (____)_____-_____ Fax: (____)_____-_____

Office Address: _____

LABS:

☐ CMP ☐ EVERY infusion ☐ every OTHER infusion ☐ other: _____

☐ Vitamin D 25 Hydroxy ☐ EVERY infusion ☐ every OTHER infusion ☐ other: _____

☐ No labs needed

BONIVA (ibandronate sodium) IV DOSAGE:

Dose: 3 mg IV bolus, over 15-30 seconds.

Frequency: Every 12 weeks for 4 treatments.

Other: _____ **Duration:** _____