Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Age related Osteoporosis without current pathological fracture	ICD 10 Code: M81.0
☐ Age related Osteoporosis with current pathological fracture	ICD 10 Code: M80.0 _____
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

- ☐ This signed order form by the provider
- ☐ Patient demographics AND insurance information
- ☐ BMP within 2 weeks of injection
- ☐ Documentation of oral hygiene

*Patient may be required to submit a pregnancy test prior to treatment

- ☐ Clinical/Progress notes (must be within 1 year)
- ☐ Labs and Tests supporting primary diagnosis
- ☐ DEXA scan results and/or FRAX score (must be within 2 years if indicated)

List Tried & Failed Therapies, including duration of treatment:

1)

2)

3)

MEDICATION ORDERS

Dosing Wt for Calculations	Ht: Wt (in kg): BMI:
Dosing	☐ J3489 Reclast 5mg IV once yearly
Additional Dosing	☐ J3489 Reclast _____

ADDITIONAL ORDERS / INFORMATION

PRESCRIBER INFORMATION

Prescriber name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Ph. 217-258-4150
Suite 204 Fax 217-348-2579
Mattoon, IL 61938

☐ EFFINGHAM
901 Medical Park Dr. Ph. 217-342-7500
Suite 201 Fax 217-342-7499
Effingham, IL 62401

MEDICATION ORDERS - RECLAST (ZOLEDRONIC ACID)

Clinics Scan to: Physician Orders