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FAX REFERRAL FORM

ATTN: Zoledronic Acid/Denosumab Program Coordinator

Fax: 570-496-6426
Phone: 570-342-3675 x209
Date Faxed: ___/___/_____

Referring Physician's Name: _____
Referring Physician's Phone: _____
Referring Physician's Fax: _____

I am referring my patient for a:

☐ **Reclast (Zoledronic acid) infusion 5 mg IV yearly or** ☐ **Prolia (Denosumab) injection 60 mg SQ every 6 months**

*****THIS FORM MUST BE FAXED YEARLY IF YOU WANT TO CONTINUE THIS MEDICATION*****

PATIENT INFORMATION

Patient's Name: _____
Patient's Address: _____
Patient's Phone: _____ Date of Birth: ___/___/_____

DIAGNOSIS

Diagnosis: ☐ Postmenopausal Osteoporosis
☐ Osteopenia *(Reclast/Zoledronic acid only - every 2 years)*

This patient has a calculated creatinine clearance of ≥ 35 mL/min and a normal serum calcium level: ☐Yes ☐No Date of lab results: ___/___/_____
***CR Clearance for Reclast only / Calcium for Reclast & Prolia**
Patient currently taking calcium and vitamin D supplements: ☐Yes ☐No

Attach copies of the following:

☐ X Rays ☐ Dexa Scan w/i 2 yrs ☐ Lab results for BUN/Creatinine & serum calcium within last 4 weeks
☐ Current Medication List, Allergies & Physician Progress Note
☐ Insurance card(s), front and back
☐ Documentation of failure/ intolerance to oral bisphosphonates

Physician's Signature: _____ Date: ___/___/_____