HEMATOLOGY & ONCOLOGY ASSOCIATES OF NORTHEASTERN PA, PA
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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: ___/___/________