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

☐ Osteoporosis in women or men at high risk of developing fracture ICD 10 Code: M81.0

☐ 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

☐ DEXA scan results and/or FRAX score (must be within 2 years)

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

☐ Clinical/Progress notes supporting primary diagnosis (must be within 1 year)

☐ Calcium drawn on _____ (must be within the last 2 weeks) and noted to be WNL and results sent; the patient is cleared to receive the drug

List Tried & Failed Therapies, including duration of treatment:

1)

2)

3)

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI:

Biologic Injection Order

Medication	Dosing	Route	Rate of Infusion	Dates of administration
☐ J0897 Prolia	60 mg	SQ	N/A	X 1 dose**
☐ J0897 Prolia	_____	SQ	N/A	X 1 dose**

****This is a single dose order to assure that calcium levels have been reviewed.**

****Clinical monitoring of calcium, phosphorus, and magnesium is highly recommended in patients with severe renal impairment. Adequately supplement all patients with Calcium and vitamin D.**

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. Suite 204 Mattoon, IL 61938
Ph. 217-258-4150 Fax 217-348-2579

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

INFUSION ORDERS - PROLIA (DENOSUMAB)

Clinics Scan to: Physician Orders