OSTEOPOROSIS REFERRAL FORM

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:________________lbs or ____________kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- DEXA Scan
- Current Calcium Levels (within 6 months)

PRIMARY DIAGNOSIS

☐ M80.00xA Age-related osteoporosis with current pathological fracture, initial encounter
☐ M80.00xS Age-related osteoporosis with current pathological fracture, sequela
☐ M81.0 Age-related osteoporosis without current pathological fracture
☐ Other: ____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: ____

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PRE-MEDICATIONS

*Per infusion clinic protocol: (No recommended standard pre-meds for Evenity, Prolia, or Zoledronic Acid)
☐ Provider Prescribed: ____

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PRIMARY MEDICATION ORDER

☐ Evenity 210 mg (two 105 mg SubQ injections) once monthly for 12 doses
☐ Prolia 60 mg SubQ injection once every 6 months
☐ Zoledronic Acid 5 mg IV once yearly
☐ Other: ____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Flourish Health Group's protocol (See flourishhealth.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Flourish Health Group's protocol
(See flourishhealth.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

____ ____________________
Provider Signature Date

FAX: (219) 319-5121 | PHONE: 1-800-799-CARE (2273) | EMAIL: hello@flourishhealth.com | VISIT: flourishhealth.com