ZOLEDRONIC ACID Referral Order Form

FAX (855) 891-2191

Effective: 10/2016

MPP Infusion Centers

www.mppinfusion.com

Referral Phone: (855) 478-1528 Referral Fax: (855) 891-2191

Denver Arlington Dallas Duncanville Irving Lewisville Plano Southlake

New Referral | Restart | Medication/ Order Change *(New Order Required)* | Benefits Verification Only | D/C Infusions **indicate name of drug(s)* ______________

PATIENT INFORMATION

Name: ____________________ Date: ________

DOB: ______________ SS# ______________

Phone # ______________

Email: ________________________________

PHYSICIAN INFORMATION

Referring Physician: ________________________

Practice Name: ________________________

Specialty: ________________________

Office Contact: ________________________

Contact Phone # ________ Contact Fax # ________

Contact Email: ________________________

ZOLEDRONIC ACID MEDICATION ORDERS

Dosing: **5** mg IV every ____ year (s)

Patient is currently taking Calcium/Vitamin D Supplement Yes No

INDICATION/DIAGNOSIS

Postmenopausal Osteoporosis
Osteoporosis
Glucocortoid- induced Osteoporosis
Paget's Disease
Other *(please specify in notes)*

***ICD-10** ______________________ **required**

NOTES (ADDITIONAL INFO)

____
Referring Physician's Signature

____
Date *valid for one year

REQUIRED DOCUMENTATION

Recent Office notes (along with any therapies tried and outcomes)
Current Medication List
History and Physical Report
Lab Results
Insurance Cards (front and back)
Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

Creatinine (w/in 90 days)
DEXA Results (w/in 2 years)
Serum Calcium (w/in 90 days)

APPOINTMENT DATE & TIME: ______________________________

FOR OFFICE USE ONLY