Prolia

RHEUMATOLOGY CONSULTANTS of WNY

WNY Infusion Center

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note, Insurance Information, BMP (Including serum calcium, creatinine, and eGFR), DEXA scan

Please check "X" if applicable

PATIENT INFORMATION

Referral Status: _____New Referral _____Updated Order _____Order Renewal

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ____M80.0_____ ____M81.0 ____ M81.8 ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ____ New to therapy ____ Continuing Therapy Last Treatment Date: Next Due date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING (All required)

➔ T Score, Dexa (list results & date)

_____

➔ Tried and failed bisphosphonates? _____YES_____NO
If yes, list with dates:

_____

➔ List any history of fractures:

_____

LABORATORY ORDERS

___ CBC ___ at each dose ___every _____

___ CMP ___ at each dose ___every _____

___OTHER_____ ___every _____

___ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment

PRE-MEDICATION ORDERS

Pre-Medications not usually indicated

____ Other:_____

Dose:_____ Route:_____ Frequency:_____

THERAPY ADMINISTRATION

-Prolia SQ Injection
Dose: 60mg
Frequency:Every 6 Months

Refills : ___ Zero / ___ for 12 Months / _____

_____ Provider Name (Print)	_____ Provider Signature	_____ Date