# Osteoporosis & Endocrinology Referral Form

## Fax #: ______________________

### Patient Information

Patient Name: ___________________________ DOB:_____________ Date:_________________ SS#: ___________________

**Please Attach the Following Information with this Prescription:**

1. Demographics Page
2. Copay of Insurance / Rx Cards
3. Most Recent Medical History with Confirmed Diagnosis of Osteoporosis
4. Bone Density (T –Score) or Dexascan Results
4. Previous Medication History including Oral Biphosphonate Failure / Contraindication History

### Self Injection Training

______At home by a home health nurse ______At the physician's office

### Medication

**Forteo 600 mcg/2.4ml Pen** Sig: Inject 20ug SC once a day as directed
Quantity: # ________ Refills __________

**Prolia 60mg** Sig: Inject 60mg SC every 6 months
Quantity # _________ Refills __________

**Reclast 5mg/100ml** Sig: Infuse 5mg once yearly
Quantity # _________ Refills __________

**Thyrogen 1.1 mg vial (2)** Sig: Administer 0.9mg IM
Alternate Sig: __________________________ Quantity # 1 kit Refills __________

### Physician Prescription Orders

Physician Name: ___________________________ NPI #: ___________________ Phone: _____________ Fax: _______________

Address: _______________________________________ City / State: ______________________________ Nurse: ______________

Physician Signature: ___________________________________________________ Date: ________________________

*****Please include a copy of the patient's Rx insurance card and face sheet*****