ENDOCRINOLOGY REFERRAL FORM

PATIENT INFORMATION *(Complete the following or send patient's demographic sheet)*

_____ Sex □M □F _____
Last Name First Name Date of Birth

_____ _____ _____
Address Home Phone Work/Mobile Phone

_____ _____ _____ _____
Medicare # Medical # Other Facility

TREATMENT ARRANGEMENTS

• Start Date:_____ Ship Meds □ Home □ Doctor's Office •Teaching by: □ Home Health □ Doctor's Office □ Other:_____

STATEMENT OF MEDICAL NECESSITY

Diagnosis (ICD-10 code): □ M81.0 Osteoporosis □ E11.9 Non Insulin DM □ E10.9 Insulin DM □ E11.65 Insulin DM

- Is Patient using prescribed therapy in combination with other biologics for MS? □ Yes □ No
- Is Patient pregnant, nursing, or planning pregnancy? □ Yes □ No □ N/A | Allergies: _____

Patient Evaluation:

- Is the patient currently taking a bisphosphonate? □ Yes □ No
  If Yes, will current bisphosphonate therapy be discontinued upon induction of FORTEO? □ Yes □ No
- Does the patient have hypocalcemia? □ Yes □ No • Patient's Weight: _____Kgs/lbs
- Is the patient at the risk of fracture? □ Yes □ No • Patient's height: _____ inches

Bone Mineral density Results:

- DXA Results (g/cm2):_____ T-Score: _____ Date: _____
- DXA Results (g/cm2):_____ T-Score: _____ Date: _____

Prior Failed Medications: **Duration/Reason of Discontinuation**

_____ _____
_____ _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILL
□ TYMLOS	□ 3120mcg/1.56ml	Inject 80mcg SubQ once daily	30days	_____
□ FORTEO	□ 600mcg/2.4ml Device	Inject 20mcg (0.08ml) SubQ once daily	_____	_____
□ PROLIA	□ 60mg	Inject 60mg SubQ every 6 months	_____	_____
□ RECLAST	□ 5mg	Infuse 5mg IV once a year	1 vial	_____
□ GLUMETZA ER	□ 500 mg □ 1000 mg	Take one tablet by mouth once a day	_____	_____
□ SAXENDA	□ 18 mg/3 ml PEN	Inject 3mg SubQ everyday	_____	_____

ORTHOPEDICS / PROSTHETICS

BACK SUPPORT
□ Dorso-Lumbar
□ Lumbo-Sacral
□ Sarco-Lliac
□ Rib Belt

BRACE
□ Knee Brace □S □M □L □XL
□ Ankle Rt.__ Lt.__
□ Elbow Rt. __ Lt.__ //ROM Dbl. Upr.
□ Wrist Rt. __ Lt.__
□ Shoulder Rt. __ Lt. __

Other Orthopedic Support:_____

OTHER MEDICAL EQUIPMENT

□ Walker Folding // with wheel //with seat
□ Utility bath seat □ w/back
□ Commode (bedside)
□ Raised Toilet Seat
□ Bed Pan □ Urinal M/F
□ Cane Orthopedic // Quad □ Wheel pad

DIABETIC SUPPLIES

□ Blood Glucose Monitor
Date:_____ FBS=_____ □ Chemstrips _____Per Day
□ Diabetic Shoes
□ OTHER: _____

Physician Signature: _____ **Date:**_____**Office contact:**_____

Physician Name:_____ **UPIN #**_____ **NPI #**_____**DEA#**_____

Physician Address:_____ **Phone #**_____ **Fax #**_____

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