

ENDOCRINOLOGY REFERRAL FORM

PATIENT INFORMATION

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

Last Name	First Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	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
<input type="checkbox"/> TYMLOS	<input type="checkbox"/> 3120mcg/1.56ml	Inject 80mcg SubQ once daily	30days	_____
<input type="checkbox"/> FORTEO	<input type="checkbox"/> 600mcg/2.4ml Device	Inject 20mcg (0.08ml) SubQ once daily	_____	_____
<input type="checkbox"/> PROLIA		Inject 60mg SubQ every 6 months	_____	_____
<input type="checkbox"/> RECLAST	<input type="checkbox"/> 5mg	Infuse 5mg IV once a year	1 vial	_____
<input type="checkbox"/> GLUMETZA ER	<input type="checkbox"/> 500 mg <input type="checkbox"/> 1000 mg	Take one tablet by mouth once a day	_____	_____
<input type="checkbox"/> SAXENDA	<input type="checkbox"/> 18 mg/3 ml PEN	Inject 3mg SubQ everyday	_____	_____

Physician Signature: _____ Date: _____ Office contact: _____

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

Physician Address: _____ Phone # _____ Fax # _____

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