# ORTHOPEDIC 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

### STATEMENT OF MEDICAL NECESSITY

**Diagnosis (ICD-10 code):** □ M15.0 Osteoarhtritis □ M15.9 Polyosteoarthritis unspecified

- 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: _______________

### INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available ( Front and Back)

## PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DIRECTIONS | QUANTITY | REFILL |
|---|---|---|---|---|
| □ **HYALGAN** | □ 20mg/2ml Syringe<br>□ 20mg/2ml Vial | ____________ | ____ | ____ |
| □ **MONOVISC** | □ 88mg/4ml Syringe | ____________ | ____ | ____ |
| □ **ORTHOVISC** | □ 15mg/ml Syringe | ____________ | ____ | ____ |
| □ **SUPARTZ** | □ 25mg/2.5ml Syringe | ____________ | ____ | ____ |
| □ **EUFLEXXA** | □ 20mg/2ml | ____________ | ____ | ____ |
| □ **SYNVISC ONE** | □ 48mg/6ml □16mg/2ml | ____________ | ____ | ____ |

□ **Prescriber Certification:** I certify the above therapy is medically necessary and that the information above is accurate to the best of my knowledge

**Physician Signature:** _______________ **Date:**_______________**Office contact:**_______________

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

**Physician Address:**_______________ **Phone #**_______________ **Fax #**_______________

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*X By Signing this prescription & using Southside's services, you are authorizing Southside to contact insurance companies for prior authorizations on behalf of your practice.*

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