


<p>THE UNIVERSITY OF KANSAS HOSPITAL 3901 Rainbow Boulevard Kansas City, Kansas 66160 OUTPATIENT INFUSION THERAPY CLINIC</p>	<p align="center">Do not write in this box</p> 	<p>Patient Name _____ Medical Record # _____ DOB _____</p>
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RECLAST® (ZOLEDRONIC ACID) AND BONIVA® (IBANDRONATE SODIUM) REFERRAL FORM
Fax: 913-588-3079

Referring Physicians – Please complete all blanks to avoid scheduling delays

Physicians Name: _____ Pager Number: _____
Clinic phone number: _____ Fax Number: _____
Patient Phone Number: Daytime _____ Alternative _____

<input type="checkbox"/> I am sending the above patient to your facility for a Reclast® infusion (J code: J-3488).	<input type="checkbox"/> I am sending the above patient to your facility For a Boniva® infusion (J code: 1740).
<input type="checkbox"/> Postmenopausal osteoporosis (ICD-9 # 733.01) <input type="checkbox"/> Paget’s disease of the bone (ICD-9 # 731.0) <input type="checkbox"/> Male osteoporosis (ICD-9 #733.00) <input type="checkbox"/> Steroid induced osteoporosis (ICD-9 # 733.09) <input type="checkbox"/> Other: _____(ICD-9 # _____)	<input type="checkbox"/> Postmenopausal osteoporosis (ICD-9 # 733.01) <input type="checkbox"/> Other osteoporosis (ICD-9 # 733.09) <input type="checkbox"/> Other: _____(ICD-9 # _____)

Lab results:

Serum calcium level: _____ and eGFR _____.

These numbers are based on labs attained on ____/____/_____. (all lab results should be within 6-8 weeks)

I verify the patient has been prescribed and is currently taking calcium and vitamin D supplements.

I am sending with this referral a copy of:

- Lab results (Serum calcium level and eGFR)
- Reclast® order set
- Boniva® order set
- Insurance card (front and back)

Physician’s signature: _____ Date: ____/____/____ Time _____