

RECOVERY ROOM IV THERAPY, LLP.

Phone: 480-865-3322 Fax: 480-866-8189

Reclast Referral Order Form

Patient Information

Patient Name:	Patient DOB:
Patient Phone #:	Sex of Patient:

Provider Information

Ordering Provider Name:	NPI # of Prescribing Provider:
Office Contact Name:	Office Phone #:
Office Contact Fax #:	Office Contact Email:

Reclast Medication Orders

Dosage <ul style="list-style-type: none">• _____ 5mg IV once every year• _____ Other _____ Patient Weight: _____ Lbs or _____ Kg	
Diagnosis with ICD 10 code (REQUIRED) <ul style="list-style-type: none">• Diagnosis: _____ Osteoporosis _____ Paget Disease _____ Bone metastases from solid tumors _____ Giant cell tumor of bone _____ Hypercalcemia of malignancy _____ Multiple myeloma _____ Other _____• ICD 10 code _____	
Pre-Medication <ul style="list-style-type: none">• Tylenol _____ mg • Benadryl _____ mg __ IV or __ PO• Solumedrol IV Push _____ mg • Other _____	Refills <ul style="list-style-type: none">• Zero _____ • Treatments for 1 year _____• Other _____

Required Documentation

<input type="checkbox"/> Insurance Cards (Front and Back)	<input type="checkbox"/> Patient Demographics	<input type="checkbox"/> Recent Progress Notes
<input type="checkbox"/> Lab Results – Calcium within 6 months prior to treatment, CMP (Creatinine clearance must be greater than 35mL/min)		
Special Instructions/Notes		

Prescribing Provider Signature

Date of Signature