Horizon Infusions

Prolia Referral Form

Please fax completed form to (513) 386-7926. For new referrals, please include recent labs, last two office visit notes and patient demographic information.

1. PATIENT INFORMATION

Name: _____ DOB: _____
Home phone: _____ Other phone: _____
Email: _____ Social Security #: _____
Gender: _____ Height: _____
Allergies: _____ Weight: _____
ICD-10 diagnosis: _____ Years with disease: _____

2. PHYSICIAN INFORMATION

Physician's name: _____ NPI#: _____
Address: _____ TIN#: _____
City: _____ Office contact name/title: _____
State: _____ Office contact email: _____
Zip: _____ Office contact phone: _____
Office fax: _____

3. MEDICAL HISTORY *(check all that apply)*

☐ Coronary Artery Disease ☐ Diabetes *(Type I)* ☐ Renal Disease ☐ Overweight / Obesity ☐ Migraine
☐ Previous MI, DVT, CVA ☐ Diabetes *(Type 2)* ☐ Hypertension ☐ Hypercoagulable State
☐ TB skin test result: _____ Date: _____ HBV: _____
☐ Patient is currently taking calcium and vitamin D supplements ☐ Yes ☐ No
Patient has previously received a Prolia injection ☐ Yes ☐ No Date of last injection: _____
☐ Other *(specify)*: _____

4. DIAGNOSIS INFORMATION *(and year of diagnosis)*

☐ Osteoporosis (_____) ☐ Other *(specify)*: _____

5. PRESCRIPTION INFORMATION *(requires new order every 12 months)*

PROLIA

☐ Administer 60mg/ml via subcutaneous injection once (1) every six (6) months

☐ Vital signs per Horizon Infusions' protocol
☐ Anaphylaxis & hydration management per Horizon Infusions' protocol

PRE-MEDICATIONS

☐ Tylenol *(acetaminophen)*
☐ 650mg PO ☐ 1000mg PO
☐ Claritin *(loratadine)* 10mg PO *(or other non-sedating antihistamine)*
☐ Solumedrol *(methylprednisolone)*
☐ 40mg ☐ 80mg ☐ 100mg ☐ 125mg IVP over 3-5 min
☐ Other: _____
☐ No routine pre-medications necessary

6. LABS

☐ CBC w/Diff ☐ each infusion ☐ every other infusion ☐ other frequency *(specify)*: _____
☐ Hepatic Panel ☐ each infusion ☐ every other infusion ☐ other frequency *(specify)*: _____
☐ Renal Panel ☐ each infusion ☐ every other infusion ☐ other frequency *(specify)*: _____
☐ Quantiferon TB Gold, annually, last completed *(date)*: _____
☐ Serum Calcium _____mg/dL Date of first test: _____
☐ Other *(specify)*: _____ Frequency: _____

☐ Additional instructions: _____

7. SIGNATURE *(required)*

_____ _____
PHYSICIAN'S SIGNATURE DATE