Endocrinology Referral Form

Please fax completed referral form to ivira:
(302) 486-3400
Please contact office for questions:
(302) 356-0506

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PREFERRED CONTACT #:
DATE OF REFERRAL:	SECONDARY CONTACT #:
SOCIAL SECURITY NUMBER:	ADDRESS:
DATE OF BIRTH: GENDER: ☐ F ☐ M	CITY, STATE, ZIP:

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE

☐ M81.0 - Generalized Osteoporosis ☐ M81.0 - Postmenopausal Osteoporosis ☐ M81.8 - Idiopathic Osteoporosis

☐ M81.8 - NEC Osteoporosis ☐ Other:______________________________

REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

☐ 1. INSURANCE CARD (Front & Back) ☐ 2. PATIENT DEMOGRAPHICS ☐ 3. MOST RECECNT LABS ☐ 4. H & P

MEDICATION SELECTION:

Medication	Directions	Refills
Boniva® ibandronate sodium	☐ INJECT 3MG IV PUSH EVERY 3 MONTHS	REFILLS:______
EVENITY® (romosozumab-aqqg) injection 105 mg/1.17 mL	☐ INJECT 210 MG SC ONCE MONTHLY FOR 12 MONTHS	REFILLS:______
Reclast® (zoledronic acid)	☐ INFUSE 5 MG IV OVER 15-20 MINUTES ANNUALLY	REFILLS:______
FORTÉO™ teriparatide (rDNA origin) injection	☐ INJECT 20 MCG SC, AS DIRECTED, DAILY	REFILLS:______
prolia® denosumab	☐ INJECT 60 MG SC ONCE EVERY 6 MONTHS	REFILLS:______
TYMLOS® (abaloparatide) injection	☐ INJECT 80 MG SC ONCE DAILY IN PERIUMBILICAL REGION	REFILLS:______
PEN NEEDLES	☐ 30 GAUGE ☐ 31 GAUGE ☐ 32 GAUGE	

PRESCRIBER INFORMATION:

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	LICENSE #:
CITY, STATE, ZIP:	NPI:

PHYSICIAN SIGNATURE: DATE: