



The Seattle Arthritis Clinic

10330 Meridian Avenue North
Suite 250 ▪ Seattle, Washington 98133
Ph: (206) 368-6123 ▪ Fax: (206) 368-6178
www.theseattlearthritisclinic.com

Bisphosphonate (Reclast/Boniva) Fax Referral Form

Fax this completed form to (206) 368-6178 attention Adriane

PATIENT INFORMATION:

Name _____
Address _____
Phone _____ Date of Birth _____

MEDICAL INFORMATION:

Diagnosis: Postmenopausal Osteoporosis (733.01) Paget's (731.0) Osteoporosis (733.00)

PRE-SCREENING SAFETY ISSUES:

- (a) Reclast: patient must have creatinine clearance above 35ml/min and a normal serum calcium level
(b) Boniva: patient must have creatinine clearance above 30ml/min and a normal serum calcium level
 Yes No
- Patient is currently taking Calcium and Vitamin D supplements and has been instructed that it is crucial to take adequate Calcium and Vitamin D for at least 2 weeks after the infusion.
 Yes No

INFORMATION TO FAX ALONG WITH THIS REFERRAL FORM:

- Both Primary and Secondary insurance information. Please copy front AND back of card(s) and fax back along with this form. If unable to copy, please provide insurance name, phone number, policy #, group #, and policy holder name.
- Lab results including eGFR and serum calcium. If no eGFR is available, send serum creatinine and provide patient's age _____ and weight _____ (lbs) here.

PRESCRIPTION FOR IV BISPSPHONATE:

Infuse Reclast 5mg IV over no less than 15 minutes. Inject Boniva 3mg IV over 1-2 minutes.

Ordering Clinician's signature _____

REFERRING PROVIDERS INFORMATION:

Name _____
Phone _____ Fax _____

FAX BACK INFUSION CONFIRMATION

Your patient successfully completed the infusion. Date of infusion ____ / ____ / ____.

Infusion center comments (if any) _____