PIEDMONT ARTHRITIS CLINIC, P.A.

RHEUMATOLOGY

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BONIVA INJECTION REFERRAL FORM

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____ CITY: _____ ST _____ ZIP _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

PCP: _____ PCP I

DOB: _____ SOCIAL SECURITY #: _____ EMPLOYER: _____

INSURANCE: _____ INS. ID#: _____ RESP. PARTY: _____

REFERRING PROVIDER:

LAST NAME: _____ FIRST NAME: _____

□ MD □ DO □ NP UPIN# _____ NPI# _____

ADDRESS: _____ CITY: _____ ST _____ ZIP _____

CONTACT NAME: _____ PHONE #: _____ FAX #_____

HISTORY:

□ PATIENT IS A POSTMENAPAUSAL FEMALE; **AND**
(CHECK ONE)
- □ INTOLERANT OF BIPHOSPHONATE THERAPY, **OR**
- □ FAILED TO DEMONSTRATE ACCEPTABLE RESPONSE TO 3 MO TRIAL OF ORAL BIPHOSPHONATE, **OR**
- □ DEMONSTRATES A DEGREE OF OSTEOPOROTIC SEVERITY THAT WOULD CONTRAINDICATE TRIAL.

BONE MINERAL DENSITY DONE WITHIN PAST TWO YEARS? _____ T-SCORE_____

DOES PATIENT HAVE HISTORY OF OSTEOPOROTIC FRACTURES? _____

PRIMARY DIAGNOSIS: _____

IS THERE A PREFERENCE FOR TREATING PHYSICIAN? □ NO □ YES: _____

SERVICES REQUESTED:

□ EVAL AND TREAT WITH BONIVA INJECTION **ONLY**. □ BONE MINERAL DENSITY TEST

□ EVAL AND TREAT FOR OTHER **RHEUMATOLOGIC** CONDITION (DX: _____)

PLEASE FAX THE FOLLOWING TO 864-271-4092

□ THIS **COMPLETED** FORM
□ COPY OF PATIENT'S INSURANCE CARD(S)
□ APPLICABLE LAB AND/OR IMAGING TEST REPORTS
□ APPLICABLE MEDICAL RECORDS

APPOINTMENT DATE, TIME AND DOCTOR: _____