

**Patient Information**

|   |                |                    |                |   |     |    |
|---|----------------|--------------------|----------------|---|-----|----|
| Patient Name:   |                | DOB:               |                |   |     |    |
| Patient Phone:  |                | Patient Email:     |                |   |     |    |
| NKDA  | Allergies:     | Weight lbs/kg:     | Height:        |   |     |    |
| Patient Status:   | New to Therapy | Continuing Therapy | Therapy Change | Last infusion date (if applicable): _____   |     |    |
| Is the patient pregnant, planning a pregnancy or nursing: |                | Yes                | No             | Does the patient need interpreter services: | Yes | No |

**Provider Information**

|                            |  |                             |        |      |
|----------------------------|--|-----------------------------|--------|------|
| Referral Coordinator Name: |  | Referral Coordinator Email: |        |      |
| Ordering Provider:         |  | Provider NPI:               |        |      |
| Referring Practice Name:   |  | Phone:                      | Fax:   |      |
| Practice Address:          |  | City:                       | State: | Zip: |

**ICD-10 CODE**

M81.0 Age-related osteoporosis without current pathological fracture      Other: \_\_\_\_\_  
M81.8 Other osteoporosis without current pathological fracture

**Medication Order**

**Ibandronate**      Dose: 3mg IV      Frequency: Every 3 months

**Documentation Required (Note: Send all labs, must include specific labs listed here)**

Labs (Calcium, Creatinine)

Insurance Card (front and back)

Current Medications

History/Progress Notes

**Special Instructions (Prior therapy, treatment dates, and reasons for d/c)**

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

Order Expiration Date (mm/dd/yy): \_\_\_\_\_ (If not indicated order will expire one year from date signature) Check here if this is a stat order

**Patient Information**

|                |          |      |   |   |
|----------------|----------|------|---|---|
| Patient Name:  | DOB:     | Sex: | M | F |
| Patient Phone: | Fasting: | Y    | N |   |

**Lab Test (Please circle or write in ICD-10)**

|                           |  |   |   |
|---------------------------|--|---|---|
| ALT                       | R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21                      | HIV VIRAL LOAD                              | Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20                       |
| AST                       | R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21                      | IgE   | J45.4, J45.3, L50.9, J45.40, J45.50   |
| HEPATIC FUNCTION PANEL    | R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21                      | IgG   | G35, G36.0  |
| BASIC METABOLIC PANEL     | I10, E87.1, Z79.899, E87.5, E80.20, G35, M81.0, M81.8, N18.9                           | IMMUNOGLOBULIN QUANT IgG, IgM, IgA          | G35, G36.0  |
| CALCIUM                   | M81.0, M81.8   | IMMUNOGLOBULIN QUANT IgG, IgM, IgA, IgE     | G35, G36.0  |
| CBC (INCLUDES DIFF/PLT)   | I10, D64.9, Z00.00, R53.83, G35, C50.011, D70.9, D50.0, D63.1                          | IRON, TIBC, FER PNL                         | D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9                            |
| CBC (H/H, RBC, WBC, PLT)s | I10, Z00.00, Z13.0, D64.9, G35, C50.011, D70.9, D50.0, D63.1                           | LIPID PANEL                                 | Z79.899, E78.5, E55.9, E78.00, Z00.00, E78.01, E78.2                        |
| COMP METABOLIC PANEL      | I10, Z79.899, E78.5, E11.9, E78.2, E80.20, G35, M81.0, M81.8, N18.9                    | MAGNESIUM                                   | I10, Z79.899, R25.2, E83.42, Z00.00   |
| CREATININE                | M81.0, M81.8, G35  | PSA   | R97.20, C61, N40.1, Z12.5, N40.0  |
| C-REACTIVE PROTEIN (CRP)  | R53.83, R79.82, M35.3, I10, M06.9, K50.90, K51.90, M32.9, L40.50                       | PROTHROMBIN TIME-INR                        | Z79.01, I48.91, I48.0, Z51.81   |
| FERRITIN                  | D64.9, D50.9, D50.0, D50.8, Z00.00, D63.1, N18.9                                       | TRANSFERRIN SATURATION                      | D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9                            |
| G6PD                      | M1A.9XX0, M1A.9XX1   | QUANTIFERON TB GOLD                         | Z79.899, Z00.00, Z01.84, M06.9, M08.9, M45.0, L40.0, L40.50, K51.90, K50.90 |
| GROWTH HORMONE            | E22, C7A.1, E34  | TSH   | E03.9, I10, E03.8, R53.83, E06.3, E05.00                                    |
| HBSAG CONFIRMATION        | Z11.3, Z36.9, Z20.2, Z11.59, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0          | URIC ACID                                   | M10.9, E79.0, I10, Z00.00, M1A.9XX0, M1A.9XX1                               |
| HEMOGLOBIN & HEMATOCRIT   | D50.9, D64.9, D50.0, D63.1, N18.9  | VIT B12/FOLIC ACID                          | M89.49, E53.8, R53.83, F41.8, F41.9, E05.00                                 |
| HEMOGLOBIN A1C            | E11.9, E11.65, R73.01, Z00.00, I10   | VIT D 25- HYDROX                            | E55.9, Z00.00, R53.83, I10, Z79.899, M81.0, M81.8                           |
| HEP B SURF AG             | Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0 | Miscellaneous Labs<br>Not Listed (Write In) |   |
| HIV 4TH GEN               | Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20                                  |   |   |
| HIV 1/2 AB DIFF           | Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20                                  |   |   |

**Frequency**

|                    |                  |                             |
|--------------------|------------------|-----------------------------|
| Prior to each dose | Yearly           | Other: Please Specify Below |
| Lab Test: _____    | Frequency: _____ |                             |
| Lab Test: _____    | Frequency: _____ |                             |
| Lab Test: _____    | Frequency: _____ |                             |
| Lab Test: _____    | Frequency: _____ |                             |

Provider Name

Provider Signature

Date

Provider Phone