Eaton Rapids Medical Center

Reclast Referral Form

Patient Information **Appointment Date_____** **Time_____**

Date_____ Patient SSN _____ ☐Male ☐Female
First Name_____ Last Name_____
Address_____City_____State_____Zip_____
Home Phone_____ Alternate Phone_____
DOB_____Height_____Weight_____
Allergies_____
_____

The following section must be completed in full with Physician signature before infusion will be scheduled.

Pre- infusion blood values for this patient are **MANDATORY** and must be drawn within 30 days of infusion:
(Patient must be instructed on when to have labs drawn).

Calculated Creatinine Clearance (must be ≥ 35ml/min) _____
Serum Calcium Level (must be within normal limits) _____
Patient currently taking Calcium supplements: ○ **Yes** ○ **No** and/or Vitamin D supplements: ○ **Yes** ○ **No**

Diagnosis: _____

Prescription: Single Reclast 5 mg IV infusion per protocol.

Physician's Signature_____Date_____Time_____

Physician tax ID#_____ Phone #_____ Fax#_____

Insurance Information (Fill out entirely and fax insurance cards-both sides)

Primary Insurance_____ Secondary Insurance_____
Insured_____ Insured_____
Phone_____Phone_____
Policy #_____Policy#_____
Has patient been notified of insurance authorization? ☐ Yes ☐ No

Reclast 5 mg IV Infusion infused on _____ by _____ and faxed to Physician.
Date Nurse Initials

STATEMENT OF CONFIDENTIALITY: Data, records and knowledge, including meeting minutes, collected for or by individuals or committees assigned peer, professional and/or quality review functions are confidential, are not public records and are not available for court subpoena in accordance with Michigan Compiled Laws §§ 333.20175, 333.21513, 333.21515, 331.531, 331.532 and 331.533.