

LOTUS HEALTH HOUSTON
 INFUSION SERVICES
 3569 BUSINESS CENTER DR SUITE 160
 PEARLAND, TEXAS 77584

Fax To: (877) 643-0993
 Email To: INFUSIONS@LOTUSHH.COM
 Have a Question? Call: (832) 284-4452

ZOLEDRONIC ACID ORDER FORM

REFERRAL STATUS			
<input type="checkbox"/> New Referral <input type="checkbox"/> Order Renewal <input type="checkbox"/> Restart <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> D/C Infusion (Medication(s) to D/C _____)			
LOCATION			
<input type="checkbox"/> Denver <input type="checkbox"/> Arlington <input type="checkbox"/> Dallas <input type="checkbox"/> Duncanville <input type="checkbox"/> Irving <input type="checkbox"/> Lewisville <input type="checkbox"/> Plano <input type="checkbox"/> Southlake <input type="checkbox"/> Tyler			
PATIENT INFORMATION			
PATIENT NAME:		DOB:	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ADDRESS:		PHONE #:	
WEIGHT: _____ LBS _____ KG	HEIGHT: _____		EMAIL: _____
ALLERGIES:			
Please check that the following are included	<input type="checkbox"/> Patient demographics and insurance attached		<input type="checkbox"/> Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached
	<input type="checkbox"/> Current Medication List	<input type="checkbox"/> Creatinine (w/in 90 days)	<input type="checkbox"/> DEXA Result
	<input type="checkbox"/> Serum Calcium (w/in 90 days)	Patient is currently taking Calcium/Vitamin D Supplement <input type="checkbox"/> Yes <input type="checkbox"/> No	
PHYSICIAN INFORMATION			
Physician Name:		Email (if you would like referral updates):	
Practice Name:		Phone Number:	
Office Contact:		Fax Number:	
DIAGNOSIS			
<input type="checkbox"/> Postmenopausal Osteoporosis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other:	
<input type="checkbox"/> Glucocorticoid-induced Osteoporosis	<input type="checkbox"/> Paget's Disease		
ICD-10 CODE:		Date of last infusion/injection:	
MEDICATION ORDERS			
ZOLEDRONIC ACID ORDERS: Dose: 5mg IV every _____ year(s) Physician Signature _____ Date (Order is Valid for One Year) _____ Infusion will be administered per MPP policy and protocol			Notes/Comments
STANDING LAB ORDERS			
<input type="checkbox"/> Labs to be Drawn by Infusion Center Frequency: <input type="checkbox"/> Every Infusion <input type="checkbox"/> Other (please specify) _____			
<input type="checkbox"/> CMP <input type="checkbox"/> CBC <input type="checkbox"/> CRP <input type="checkbox"/> ESRP <input type="checkbox"/> HFR <input type="checkbox"/> UA			
MPP ZOLEDRONIC ACID ORDER FORM_07/2017			