

Osteoarthritis

Ph: (214) 919-2090 or (877) 753-6878

Fax: 1 (888) 294-9434

Injection Training:	<input type="checkbox"/> MD Office
	<input type="checkbox"/> Pharmacy to Arrange
Ship To :	<input type="checkbox"/> Patient Home <input type="checkbox"/> MD Office


MAIN POINT OF CONTACT
Name: _____
Phone: _____

PATIENT INFORMATION (Use this area or attach patient demographics)					
Name: _____	Phone: _____	Phone 2: _____			
Home Address: _____	City: _____	State: _____	Zip Code: _____		
DOB: _____	SSN: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height: _____	Weight: _____	lbs.
Emergency Contact: _____	Phone: _____				

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))					
Primary Insurance: _____	Secondary Insurance: _____				
ID#: _____	RxBin: _____	ID#: _____	RxBin: _____		
RxGroup: _____	Pcn: _____	RxGroup: _____	Pcn: _____		

PATIENT EVALUATION:					
Does patient have a complete collapse of the joint space or bone loss? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does patient have skin diseases or infection in or around the affected joint? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If patient has tried simple analgesics, please name and include strength and duration: _____					
Has patient received previous course of treatment with dyaluronidase? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes, how long ago? _____ months					
Did patient experience pain relief? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does patient have extensive inflammation with joint effusion or an inflammatory flare? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has patient been treated with simple analgesics in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Unilateral or bilateral treatment? <input type="checkbox"/> Unilateral <input type="checkbox"/> Bilateral					
Patient Weight: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs					
Concomitant Medications: _____					
Allergies: _____					

MEDICATION INFORMATION:				
Medication	Strength	Directions	Qty.	Refills
<input type="checkbox"/> Orthovisc <input type="checkbox"/> Include one 20G 1.5" needle per syringe	<input type="checkbox"/> 30mg/2ml Syringe	Inject contents of prefilled syringe intra-articulary once a week for _____ weeks		
<input type="checkbox"/> Mono Visc <input type="checkbox"/> Include one 20G 1.5" needle per syringe/vial	<input type="checkbox"/> 88mg/4ml	Inject contents of prefilled syringe intra-articulary one time		
<input type="checkbox"/> Euflexxa <input type="checkbox"/> Include one 20G 1.5" needle per syringe	<input type="checkbox"/> 20mg/2ml Prefilled Syringe	Inject contents of prefilled syringe intra-articulary once a week for 3 weeks		
<input type="checkbox"/> Supartz <input type="checkbox"/> Include one 23G 1.5" needle per syringe	<input type="checkbox"/> 25mg/2.5ml Prefilled Syringe	Inject contents of prefilled syringe intra-articulary once a week for 5 weeks		
<input type="checkbox"/> Synvisc One <input type="checkbox"/> Include one 20G 1.5" needle per syringe	<input type="checkbox"/> 48mg/6ml Prefilled Syringe	Inject contents of prefilled syringe intra-articulary one time		
<input type="checkbox"/> Synvisc <input type="checkbox"/> Include one 20G 1.5" needle per syringe	<input type="checkbox"/> 16mg/2ml Prefilled Syringe	Inject contents of prefilled syringe intra-articulary once a week for 3 weeks		


ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name: _____	NPI#: _____
Address: _____	City: _____ State: _____ Zip Code: _____
Phone: _____	Fax: _____

*Prescriber Signature: _____	Date: _____
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