SA Infusion Services

ZOLEDRONIC ACID

Email all Referrals to: *info@sainfusion.com.au*
OR Fax to: (08) 7081 7038

139, Payneham Rd,
St Peters SA 5069

PATIENT DETAILS

Name: _____

Address: _____

Date of Birth: _____

Contact Phone: _____

REFERRER DETAILS (or stamp)

Doctor Name: _____

Provider No.: _____

Practice: _____

Fax or Email: _____

*** Note:** *the referring GP or referring specialist is required to provide the patient with a script for IV zoledronic acid at the time of referral*

A. CLINICAL INDICATION

(please tick which clinical scenario applies)

- ☐ Osteoporosis
- ☐ Paget's Disease
- ☐ Post-Denosumab Transition
- ☐ Other - *please specify:*

B. PATIENT SCREENING

Patient Age: _____

Is the patient pregnant?

○ Yes ○ No

Is the patient breastfeeding?

○ Yes ○ No

Has the patient had a dental check in the last 6 to 12 months?

○ Yes ○ No

Allergies:

_____

By completing and signing this referral form, I confirm that the referred patient DOES NOT have:

- ❌ Any acute illnesses at the time of referral
- ❌ Any history of osteonecrosis of the jaw
- ❌ Untreated vitamin D deficiency
- ❌ Any concern for atypical femur fracture
- ❌ Any issues maintaining hydration
- ❌ Any history of hypocalcemia
- ❌ Known bisphosphonate hypersensitivity
- ❌ Any unreviewed dental issues
- ❌ Any planned invasive dental procedures (eg. extractions, implants, root canals)

C. PATHOLOGY CRITERIA

I confirm I have attached pathology results which have been performed within the last 90 days and demonstrate each of the following *(please tick each to confirm)*:

- ☐ **Corrected Calcium Level ≥ 2.20 mmol/L**
- ☐ **Vit D Level ≥ 50 nmol/L**
- ☐ ***Magnesium Level within normal range (optional - up to the discretion of the referrer)***
- ☐ **eGFR ≥ 35 mL/min**
- ☐ **No history of unstable and/or fluctuating renal function**

D. TREATMENT HISTORY

Is this the patient's first IV Zoledronic Acid infusion? ○ Yes ○ No

If 'No', I confirm that it has been a clinically safe time interval since last infusion: ○ Yes ○ No

Has the patient previously been on Denosumab? ○ Yes ○ No

If 'Yes', what was the date of last administration? _____

Note: *Optimal timing of IV Zoledronic Acid is 6 months after last administration of Denosumab*

E. REFERRER CHECKLIST

(please tick each to confirm)

☐ I have provided the patient with a script for IV Zoledronic Acid

☐ I have attached results of blood tests performed within the last 30 days (including calcium level, vitamin D level and eGFR)

☐ I have informed the patient that they MUST AVOID any anti-inflammatory medications and any diuretic medications for 24 hours before and after the IV Zoledronic Acid infusion *(note: unless clinically inappropriate to hold diuretics and with the exception of oral corticosteroid use pre/post the patient's first Zoledronic Acid infusion)*

F. ADDITIONAL INFORMATION / SPECIAL INSTRUCTIONS

If you have any pertinent additional information in relation to the referred patient's clinical situation, any exceptions to the outlined criteria in this referral form or special instructions for administration, please outline them below:

REFERRER ACKNOWLEDGEMENT

By signing this referral form, the referrer confirms that they have assessed that it is clinically appropriate for the referred patient to receive IV Zoledronic Acid, all contraindications have been excluded, any abnormalities in calcium, vitamin D and renal function have been corrected prior to referral & all potential side effects and risks of Zoledronic Acid have been explained to the patient.

By signing this referral form, the referrer also fully acknowledges and accepts that investigation of the underlying cause(s) of osteoporosis / bone disease, treatment sequencing, and ongoing management and follow-up after the IV Zoledronic Acid infusion are not the responsibility of SA Infusion Services and remain solely the referrer's responsibility. The referrer accepts that it is their responsibility to advise the patient regarding the plan for calcium supplementation and vitamin D supplementation before and after the IV Zoledronic Acid infusion, as they see clinically appropriate.

Date: _____ GP / Referrer Signature: _____