



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

Symptomatic 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 planned invasive dental procedures (eg. extractions, implants, root canals)
- Any issues maintaining hydration
- Any history of hypocalcemia
- Known bisphosphonate hypersensitivity
- Any unreviewed dental issues

C. MANDATORY CLINICAL 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 \geq 2.20 mmol/L

Vit D Level \geq 50 nmol/L

Magnesium Level within normal range

eGFR \geq 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 it has been \geq 12 months since the last IV Zoledronic Acid 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 90 days (including calcium level, vitamin D level, magnesium 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

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: _____