Referral Form for Zoledronic Acid (Aclasta™) infusion

● Thank you for referring your patient to Top Health Doctors for Aclasta infusion.
● We go through a detailed formal consent process with your patient before we provide the Aclasta ™ infusion on a separate second appointment.

Patient Information

Title: First Name: Surname:
Phone No: Email:
Address:

1.**Indication (as tick):**

◯ Osteoporosis ◯ Corticosteroid – induced osteoporosis ◯ Symptomatic Paget's Disease

◯ Others (Please elaborate): _____

2.Please provide the patient with a script for Aclasta ™

3. Please write down the rate of infusion (in minutes) that you would like us to perform the infusion (minimum is 15 minutes). _____Minutes

4. How many times have your patient had Aclasta ™ Infusion (please tick)?

◯ Zero (their first time) ◯ Once (their second time) ◯ Twice (their third time)

◯ Others, please elaborate: _____

5. Could you provide the following for your patient to bring to us:

● The initial Bone Mineral Density Scan that make them eligible under PBS (if it is for osteoporosis)
● Latest renal function test including Calcium level
● Latest Vit D level

6. Aclasta ™ infusion is usually given once a year for a maximum of 3 years. If you want to vary this, can you kindly elaborate as per below:

_____

_____

7. Other Comments:

_____

_____

Dr _____ **Company stamp or signature:**

Date: / /

Please kindly give the referral form and the accompanying information to your patient