MOOROOLBARK SPECIALIST CENTRE
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256 Hull Road, Mooroolbark 3138
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ZOLEDRONIC ACID (ACLASTA) INFUSION REFERRAL FORM

Patient Details
Full Name: _____

DOB: ___ / ___ / _____ Phone: _____

Address: _____

Email: _____

Indication (tick one)
☐ Osteoporosis (no fractures)
☐ Osteoporosis (previous fractures)
☐ Paget's disease

Infusion Timing
☐ Within 2 weeks (limited availability – please call to confirm)
☐ Within 1 month
☐ Next available
☐ By date: _____

Infusion duration:
☐ 15 mins (standard)
☐ 30 mins (eGFR 35–59)
☐ 45+ mins – requires doctor/nurse approval, limited slots
Reason if >30 mins: _____

Treatment History
Previous osteoporosis therapy:
☐ Zoledronic Acid (see below) (last dose: _____)
☐ Oral bisphosphonates
☐ Denosumab (last inj: _____)
☐ Romosozumab (last inj: _____)
☐ Teriparatide (last inj: _____)
☐ Other: _____

If had prior Zoledronic Acid please give details of previous side effects: _____

Dental Clearance
☐ No current dental issues (and recent dental check)
☐ Recent dental issues – clearance obtained (include letter if available)

Special Risks
Please tick if they have had these issues in the past:
☐ Atypical fracture
☐ Osteonecrosis of jaw
If ticked, include details & written patient consent (not verbal). Referral will be reviewed by Dr Miriam Bartlett before booking.

Infusions available Wednesdays & Fridays (selected dates).
Each patient will be reviewed by an Endocrinologist (usually Dr Miriam Bartlett or Dr Wanling Wen) on the day of infusion, followed by the infusion with our clinic nurse.
Time at clinic: 1–1.5 hours.
Cost: $325 (approx. $151 Medicare rebate - Item 110). Not claimable on private health. Payment required on the day.

Patient Consent

I, _____ (patient name), consent to receive Zoledronic Acid for:
□ Osteoporosis □ Paget's disease

I understand the risks, including:

- Flu-like symptoms/bone aches (common after 1st infusion, usually mild, up to 3 days)
- Osteonecrosis of the jaw
- Atypical fractures (incl. femur fracture)

Patient signature: _____ Date: ___ / ___ / _____

□Consent obtained verbally (e.g. Telehealth)

Doctor name: _____ Signature: _____

Referral Checklist
□ This referral form (completed)
□ Referral to **Dr Miriam Bartlett** (include conditions, medications, reason for infusion) - this is to meet the Item 110 criteria.
□ Recent bloods (within 3 months) – must include **U&E** and **Vitamin D**
□ **Script for Zoledronic Acid to be given to the patient** (patient to bring medication on the day)

Please send referral form, bloods, and referral letter together to book. We will contact the patient to arrange an appointment.

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