

Aclasta Infusion - Patient Referral & Consent for Treatment

Patient Details			
First name:		Last name:	
Gender:		Date of Birth:	
Address:			
State:		Postcode:	
Email:		Mobile Phone:	
Patient Emergency Contact:		Phone:	
Prescribing Doctor's Details			
First name:		Last name:	
Clinical Address:			Postcode:
Phone:		Email:	
Provider No:			
Medical Details Required			
Has the patient had an Aclasta infusion before? <input type="checkbox"/> Yes <input type="checkbox"/> No			
I confirm it has been at least 12 months since the last Aclasta infusion <input type="checkbox"/> YES			
eGFR Result:		Date of Result:	
Prescribing Prescribing Orders			
Medication	Route	Dose	Frequency
Zoledronic Acid	IV	5mg	Once Only
Infusion will be administered as per product information			
Special Instructions:			
<input type="checkbox"/> Paracetamol prior to and for three days following procedure.			
<input type="checkbox"/> Adequate hydration – two glasses of water prior and following procedure.			
<input type="checkbox"/> I understand that in the rare case that a patient displays an acute reaction in the presence of a nurse, during or after a Zoledronic Acid infusion, the nurse may administer emergency medication in accordance with the infusion company's anaphylaxis protocol.			
Doctor Signature		Date of Order:	
<input type="checkbox"/> I HAVE GIVEN THE PATIENT THEIR PRESCRIPTION AND INSTRUCTED THEM TO BRING IN MEDICATION THEM TO THE PHARMACY ON THE DAY OF THE INFUSION APPOINTMENT.			
The doctor has discussed the Aclasta® Infusion Support Program with me and I understand that by signing this consent I give my permission for the information contained within this form to be shared with the organisations providing this service. In the event of an adverse event occurring I understand that the healthcare professional may choose to make a report of the incident to the product provider. If I have elected to have the infusion provided to me at home I agree to being contacted by the service providers for payment. I agree to pay the patient co-payment of Pharmaceutical Benefits Scheme (PBS) medicines supplied to me at the home or clinic visit.			
Patient Signature (<i>sign on above line</i>)		Date:	
Fees: The fee for a Aclasta Infusion is \$180.00 .			
A \$80 deposit is required at the time of booking, with the remaining amount payable on the day of the procedure.			
Please Email referral & prescriptions to: info@mckinleymc.com.au			Phone: (03) 9795 4011