The Doctors Silverstream
Silverstream Village Shops
Whiteman's Road, Upper Hutt 5142
Email administration@ss.thedoctors.co.nz
Phone 04 5277 376

Dear

Re: Zolendronate (Aclasta®) Infusion

Thank you for your enquiry regarding the Aclasta infusions as The Doctors Silverstream is a referral site where you could send your patients for their infusion in a primary care setting.

Our expectation is that a referring GP is responsible for the screening, prescribing and preparation of the patient, and could refer patients to us for the infusion.

This can be expected to be a 60 minute consultation with an IV-qualified nurse.

Please find attached a referral letter should you wish to consider this option for your patients. When we receive a referral letter for a patient, we will contact them and discuss the procedure, side effects and their prophylaxis, cost and expectations. Once treatment has been provided, we will then notify the referring doctor so that they can update their records/recalls and we encourage patients to report any adverse reactions to their GP's.

Information regarding Aclasta® can be found on the website www.aclasta.co.nz and for further information, please feel free to contact us at The Doctors Silverstream.

We look forward to working with you.

Kind regards,

Practice Nurse

The Doctors Silverstream
nurse@ss.thedoctors.co.nz

Zolendronate (Aclasta®) Infusion Referral

Please fill in this form and return it to
The Doctors Silverstream
Silverstream Village Shops
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P: 04 5277 376

1 PATIENT'S DETAILS

Patient's name _____

Address _____

_____

Date of birth _____

Phone (Home) _____

Phone (Work) _____

Phone (Mobile) _____

NHI _____

2 CHECKLIST FOR REFERRAL

Is patient's eGFR >35ml/min? Yes ☐ No ☐

Is patient on Vitamin D or had a loading dose of Vitamin D? Yes ☐ No ☐

Is patient's serum Calcium normal? Yes ☐ No ☐

Have you checked that the patient's current list of medications has no contraindications to prescribing Aclasta? Yes ☐ No ☐

Has the patient been given the prescription for the Aclasta®? Yes ☐ No ☐

Has the patient been advised to stop taking any oral bisphosphonates? Yes ☐ No ☐

3 DOCTOR'S DETAILS

Referring Doctor _____

Address _____

_____

Signature _____

Date of signature _____

All Casual Patients are required to pay for their Doctors visits before their appointment