

Dear

**Re: Zolendronate (Aclasta®) Infusion**

Thank you for your enquiry regarding the Aclasta infusions as Silverstream Health Centre Ltd is a referral site where you could send your patient's 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, at the cost of \$130 (no extra charge for casual patients).

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](http://www.aclasta.co.nz) and for further information, please feel free to contact us at Silverstream Health Centre.

We look forward to working with you.

Kind regards,

Jane Morris

Primary Health Care Nurse  
Silverstream Health Centre Ltd  
[jane.morris@hv.radiusmedical.co.nz](mailto:jane.morris@hv.radiusmedical.co.nz)

Please fill in this form and return it to  
Silverstream Health Centre  
Silverstream Village Shops  
Whiteman's Road, Upper Hutt 5142  
Phone 04 5277 376 Fax 04 5283 278

**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 \_\_\_\_\_