

## ZOLEDRONIC ACID INFUSION SERVICE - Patient Referral for Treatment

Step 1: PRESCRIBING DOCTOR details			
First name:		Last name:	
Clinic address:		State:	Postcode:
Phone: (0 )		Fax: (0 )	
Email:		Provider number:	

Step 2: PATIENT details			
First name:		Last name:	
Gender: M <input type="checkbox"/> F <input type="checkbox"/>		Date of birth: DD /MM / YYYY	
Mailing address:		State:	Postcode:
Phone: (0 )		Mobile:	
Emergency contact:		Relationship:	Phone:

Step 3: PATIENT history			
Has the patient had a Zoledronic Acid infusion previously?		NO <input type="checkbox"/> YES <input type="checkbox"/>	Date if known: DD /MM / YYYY
Does the patient have any known allergies?		NO <input type="checkbox"/> YES <input type="checkbox"/>	Details:
Has the patient had / likely to have an invasive dental procedure within the last / next 3 months (e.g. root canal)? NO <input type="checkbox"/> YES <input type="checkbox"/>			

Step 4: MEDICATION ORDER				
Medication <b>Zoledronic Acid</b>	Route <b>IV</b>	Dose <b>5mg</b>	Frequency <b>Once only</b>	<b>RECORD OF ADMINISTRATION</b> (to be completed by the nurse)
				<b>Date</b>
				<b>Time</b>
				<b>Dose</b>
				<b>Nurse Name</b>
<i>Infusion will be administered as per approved Product Information.</i>				
Special instructions:				Nurse signature:
<input checked="" 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 the infusion, the nurse may administer emergency medication in accordance with the Sonic Nurse Connect anaphylaxis protocol.				
<input checked="" type="checkbox"/> I have explained to my patient they will be contacted by Sonic Nurse Connect to arrange an appointment for an infusion and they have provided their consent to this.				
<input checked="" type="checkbox"/> I have given the patient their prescription and instructed them to bring their medication to the infusion appointment.				
Prescribing Doctor Signature:				Date of Order:

Step 5: INFUSION LOCATION DETAILS	
<input type="checkbox"/>	<b>SONIC NURSE CONNECT Community Infusion Centre</b> (convenient location arranged in consultation with the patient) <b>OR</b> <i>subject to assessment and nurse availability:</i>
<input type="checkbox"/>	My Rooms / Clinic
<input type="checkbox"/>	Patient's Residential Aged Care Facility
<input type="checkbox"/>	Patient's Home ( <b>please note that a fee will be payable by the patient for the home infusion service</b> )

STEP 6: PLEASE SEND COMPLETED FORM TO SONIC NURSE CONNECT		
	EMAIL: infuse@snc.com.au	 FAX: 1800 880 683
	PHONE: 1800 INFUSE (1800 463 873) for further information	

Our Privacy Policy is available to view at [www.snc.com.au](http://www.snc.com.au) or you can request a copy by contacting us on 1800 687 726.