Hunter Valley Haematology

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# Zoledronic Acid Infusion Referral

**Dr Karan S Makhija, Dr Wojt Janowski, Dr Ritam Prasad, Dr Sam Yuen**

| Patient Name | | DOB | | Mobile | |
|---|---|---|---|---|---|
| Address | | | | | |

Thank you for reviewing this patient for provision of a zoledronic acid infusion.

I have discussed indications and side effects with the patient.

I have provided a prescription and dose for zoledronic acid to the patient and instruced them to bring the medication to their appointment.

**Zoledronic Acid Dose**

Check one: ☐ 4mg ☐ 5mg ☐ Other

**Comments:**

**Please include latest Creatinine, eGFR and corrected calcium. If not done in last 30 days, please provide patient with a pathology request form to perform prior to infusion**

**Referring Doctor**

| Name | | | | Provider No. | |
|---|---|---|---|---|---|
| Address | | | | Date | |
| Phone | | Fax | | E-mail | |

SEND FORM TO: admin@hvhaem.com.au fax. 02 9190 5381