



INFORMED CONSENT

Aclasta (Zoledronic Acid) Infusion

- ☐ Aclasta is 4 doses 18 months apart
- ☐ Patient information Sheet given
- ☐ Pathlab form done – creatinine & serum calcium
- ☐ Dental check done
- ☐ Stop any NSAIDs, diuretics, oral bisphosphonates, ACE inhibitors the day prior, day of, and day after infusion.
- ☐ Do they need loading dose of vitamin D, (2 colecalciferol if not already on vitamin D). Need to have the loading dose 1 week prior to infusion.
- ☐ Script for paracetamol for the few days after infusion.
- ☐ Side effects discussed
- ☐ Script given to patient for aclasta – needs to bring the medication with them to the appointment.
- ☐ Book pre-consult with the nurse

I, agree that I have received a reasonable explanation of the intent, risks, and likely outcome of the Aclasta Infusion and an explanation of alternative procedures.

I accept the advice of Dr regarding this treatment, and request that the treatment of aclasta infusion be carried out on myself by Te Kauwhata Health Centre.

I accept I need to bring the medication with me to my appointment.

Signed (patient) Date:

Signed (doctor) Date: