



**BRISBANE
ENDOCRINE
AND
METABOLIC
SPECIALISTS**

-  07 3544 1772
-  07 3544 1773
-  Admin@bemspecialists.com.au
-  Bemspecialists.com.au
-  BEMSpecialists
-  BEMSpecialists

Patient Consent – Zoledronic Acid Infusion

I, _____, DOB _____, consent to receive Zoledronic Acid infusion for the following indication(s):

- Osteoporosis
- Paget's disease

I confirm that the indication for treatment, expected benefits, and alternative treatment options have been explained to me.

I understand that potential risks and side effects may include:

- Flu-like symptoms, bone or muscle aches (commonly after the first infusion, usually mild, lasting up to 3 days)
- Osteonecrosis of the jaw (rare)
- Atypical fractures, including atypical femoral fracture (rare)
- Low calcium levels (hypocalcaemia)
- Allergic reactions (rare)

I understand that my kidney function, calcium levels, and vitamin D status have been reviewed or will be reviewed prior to the infusion, and that I have been advised to maintain adequate hydration.

I confirm that I have been advised to inform my doctor of any current dental problems or planned dental procedures and understand the importance of maintaining good oral health during treatment.

I confirm that I am not pregnant or breastfeeding.

I have had the opportunity to ask questions and am satisfied with the explanations provided.

Patient signature: _____ Date: ____ / ____ / ____

Consent obtained verbally (e.g. Telehealth)

Doctor name: _____ Signature: _____

