Name of proposed course of treatment: **Zoledronic acid**

Zoledronic acid IV infusion over 15 minutes

☐ Given every ........... weeks, continued at the discretion of the treating doctor

or

☐ One dose every 6 months for 3 years

Macmillan/CRUK leaflet given ☐

**Statement of health professional** (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

☐ I have discussed what the treatment is likely to involve (including inpatient / outpatient treatment, timing of the treatment, follow-up appointments) and location.

☐ I have recommended a dental examination before starting treatment with zoledronic acid.

**The intended benefits**

☐ To reduce and prevent symptoms and events related to the spread of the cancer to the bones, or related to myeloma

☐ Adjuvant – for post-menopausal women with early stage breast cancer, given after surgery, to reduce the risk of recurrence of cancer

☐ To manage aromatase inhibitor-induced bone loss

**Significant, unavoidable or frequently occurring risks:**

**Common side-effects:** low levels of phosphate in the blood

**Less common side-effects include:** flu-like symptoms, which can occur within 3 days after each dose (includes bone, joint and muscle pain, fever, feeling shivery); headache; feeling sick (nausea), being sick (vomiting) and loss of appetite; low levels of calcium in the blood; red or sore eyes; anaemia (low number of red blood cells); your kidneys being temporarily affected

**Other uncommon side effects include:** allergic reactions; injection site reactions; bruising and bleeding due to low numbers of platelets; blood pressure changes; changes in heart rate; damage to lungs (first signs are difficulty or discomfort with breathing)

**Osteonecrosis of the jaw:** There is an uncommon but serious risk of developing jaw problems (osteonecrosis) in people who are treated with zoledronic acid. This is when healthy bone tissue in the jaw becomes damaged and
dies. Gum disease, problems with your dentures, and some dental treatments (such as having a tooth removed) can increase the risk of this.

It is recommended to have a dental check before starting treatment; any invasive dental work including extractions should be completed at least 8 weeks before starting zoledronic acid.

It is also advised to avoid any nonurgent invasive dental work once treatment with zoledronic acid has started.

**Atypical fracture of femur:** There is a rare but serious risk of a fracture/break in the thigh bone in people who are treated with zoledronic acid. It is important to tell your doctor or nurse if you have any pain in the thigh, hip or groin area.

It is unknown whether zoledronic acid damages the development of a baby in the womb. Therefore, I have discussed the issues of protected sex. This is an issue for women only.

The patient has been advised not to become pregnant during the period of treatment.

Any other risks: ..................................................................................................................................

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<thead>
<tr>
<th>Clinician Signature</th>
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<tbody>
<tr>
<td>Signed.................. Date..........................</td>
</tr>
<tr>
<td>Full Name (print) / Job Title..........................</td>
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<td>(Forename) (Surname)</td>
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**Statement of patient**

**Patient Signature**

Please read this form carefully, which describes the benefits and risks of the proposed treatment. You have the right to change your mind at any time, including after you have signed this form.

I agree to undergo treatment with zoledronic acid. I understand the treatment and am aware of the potential side-effects arising from this treatment.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate training and experience.

Signed........................................ Name........................................

Date........................................

A witness should sign below if the patient is unable to sign but has indicated his or her consent.

Signature ........................................ Date ........................................

Name (PRINT) ..........................................................

**Statement of interpreter** (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed ........................................ Name (PRINT) ........................................ Date........

**Confirmation of consent** (to be completed by the chemotherapy nurse when the patient attends for the first dose)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the treatment to go ahead.

Signed ........................................ Name (PRINT) ........................................ Date........

Copy accepted by patient: yes/no (please ring)

Copy to be retained in patient’s notes