PROTOCOL CODE: BRAVLHRHT (PO)

DOCTOR'S ORDERS

Ht_____**cm** **Wt**_____**kg** **BSA**_____**m^2**

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE:

TREATMENT:

Start on _____ **(date)**

tamoxifen 20 mg PO daily. Mitte: _____ tablets. Repeat x _____

buserelin acetate ☐ **6.3 mg** SC every 6 weeks x 2 treatments

☐ **6.3 mg** SC every 8 weeks x _____ treatments

☐ **9.45 mg** SC every 12 weeks x _____treatments

OR

goserelin acetate ☐ **3.6 mg** SC every 4 weeks x _____treatments

☐ **10.8 mg** SC every 12 weeks x _____treatments

OR

leuprolide acetate ☐ **7.5 mg** IM every 4 weeks x _____treatments

☐ **22.5 mg** IM every 12 weeks x _____treatments

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor.

If clinically indicated:

☐ Serum Calcium and Albumin ☐ Bilirubin ☐ GGT ☐ ALT ☐ LDH ☐ Alk Phos

☐ Creatinine ☐ CA 15-3

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: