



Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at [www.bccancer.bc.ca](http://www.bccancer.bc.ca) and according to acceptable standards of care

PROTOCOL CODE: **BRAVZOL**

(Page 1 of 1)

DOCTOR'S ORDERS		Ht _____ cm	Wt _____ kg	BSA _____ m <sup>2</sup>
<b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>				
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle #:</b>		
Date of Previous Treatment:				
TREATMENT:				
zoledronic acid 4 mg IV in 100 mL NS over 15 min every 3 months x _____ treatments.				
RETURN APPOINTMENT ORDERS				
Return in <b>three</b> or _____ months (circle one) for doctor and treatment. Book Daycare <b>or chemo room (circle one)</b> x <b>one</b> or <b>three</b> treatments (circle one)				
Every treatment: <b>Serum Creatinine</b>  If clinically indicated: <input type="checkbox"/> <b>Serum Calcium</b> <input type="checkbox"/> <b>Albumin</b> <input type="checkbox"/> <b>Other tests:</b>  <input type="checkbox"/> <b>Consults:</b>  <input type="checkbox"/> <b>See general orders sheet for additional requests.</b>				
DOCTOR'S SIGNATURE:			SIGNATURE:	
			UC:	