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 and according to acceptable standards of care

PROTOCOL CODE: BRAJZOL2

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: **To be given:** **Cycle #:**

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 **three** or _____ months (circle one) for doctor and treatment.

Book Daycare or chemo room (circle one) x **one** or **three** treatments (circle one)

Every treatment: **Serum Creatinine**

If clinically indicated: ☐ **Serum Calcium** ☐ **Albumin**

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: