



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 and according to acceptable standards of care

PROTOCOL CODE: **BRAJZOL5**

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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:				
<input type="checkbox"/> zoledronic acid 4 mg IV in 100 mL NS over 15 min every 6 months x _____ treatments.				
RETURN APPOINTMENT ORDERS				
Return in six 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: <input type="checkbox"/> Serum Calcium <input type="checkbox"/> Albumin				
<input type="checkbox"/> Other tests:				
<input type="checkbox"/> Consults:				
<input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:		SIGNATURE:		
		UC:		