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(s) #:**

Date of Previous Treatment:

☐ Delay treatment _____ week(s)

☐ **Creatinine** day of treatment

May proceed with doses as written if within 28 days **Creatinine Clearance greater than or equal to 60 mL/min.**

Dose modification for: ☐ **Renal Function** ☐ **Other Toxicity**_____

Proceed with treatment based on blood work from _____

TREATMENT:

zoledronic acid 4 mg

☐ Dose Modification*: ☐ **3.5 mg OR** ☐ **3.3 mg OR** ☐ **3 mg** (select one)

IV in 100 mL NS over 15 min every 12 weeks x _____ treatments.

* see protocol for dose modification guidelines for renal insufficiency

RETURN APPOINTMENT ORDERS

Return in ☐ **twelve** or ☐ _____ weeks (select one) for doctor and treatment.
Book ☐ Daycare or ☐ chemo room (select one) x ☐ **one** or ☐ **three** treatments (select 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: