BC CANCER
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: BRAVZOL

DOCTOR'S ORDERS

Ht__________**cm** **Wt**__________**kg** **BSA**__________**m²**

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 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** (circle 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 (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: