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: MYZOL

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:

☐ 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** (select one)

IV in 100 mL NS over 15 min every ☐ **4 weeks** or every ☐ **12 weeks** (select one) x _____ treatments (up to 12 treatments if ordered every 4 weeks and up to 4 treatments if ordered every 12 weeks)

* see protocol for dose modification guidelines for renal insufficiency

RETURN APPOINTMENT ORDERS

Return in ☐ **four**, ☐ **twelve** or ☐ _____ weeks (select one) for doctor and treatment.

☐Book to ☐ Daycare or ☐ chemo room (select one) every **4 weeks** x ☐ **one,** ☐ **three,** ☐ **six,** or ☐ **twelve** treatments (select one)

OR

☐Book to ☐ Daycare or ☐ chemo room (select one) every **12 weeks** x ☐ **one,** ☐ **two,** ☐ **three, or** ☐ **four** 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:

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