



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

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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(s) #:		
Date of Previous Treatment:				
<input type="checkbox"/> Delay treatment _____ week(s)				
<input type="checkbox"/> Creatinine day of treatment				
May proceed with doses as written if within 28 days Creatinine Clearance greater than 60 mL/min.				
Dose modification for: <input type="checkbox"/> Renal Function <input type="checkbox"/> Other Toxicity _____				
Proceed with treatment based on blood work from _____				
TREATMENT:				
zoledronic acid 4 mg				
<input type="checkbox"/> Dose Modification*: 3.5 mg OR 3.3 mg OR 3 mg (circle one)				
IV in 100 mL NS over 15 min every 3 months x _____ treatments.				
* see protocol for dose modification guidelines for renal insufficiency				
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: <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:	