PROTOCOL CODE: BRAVZOL

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 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 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: ☐ **Serum Calcium** ☐ **Albumin**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: