



Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BCCA treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: BRAVTEST

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: _____					
<input type="checkbox"/> Delay Treatment _____ week(s) <input type="checkbox"/> CBC & Diff, Platelets day of treatment Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____					
TREATMENT: Testosterone 300 mg IM every 4, 3 or 2 weeks (circle one) x _____ treatments. OR Testosterone 400 mg OR 300 mg OR 200 mg (circle one) IM every 4 weeks x _____ treatments.					
RETURN APPOINTMENT ORDERS					
<input type="checkbox"/> Return in _____ weeks for Doctor.					
If clinically indicated: <input type="checkbox"/> Serum Calcium and Albumin <input type="checkbox"/> Alkaline Phosphatase <input type="checkbox"/> Hemoglobin <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.					
DOCTOR'S SIGNATURE:					SIGNATURE:
					UC: