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 or equal to 30 mL/min.

Dose modification for:  ☐ Renal Function  ☐ Other Toxicity

Proceed with treatment based on blood work from ____________________________

TREATMENT:

☐ pamidronate 90 mg IV in 250 mL NS over 1 hour every 6 months x ______ treatments.

RETURN APPOINTMENT ORDERS

Return in six or ______ months (circle one) for doctor and treatment. Book Daycare 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: