**DOCTOR’S ORDERS**

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<thead>
<tr>
<th>Ht</th>
<th>cm</th>
<th>Wt</th>
<th>kg</th>
<th>BSA</th>
<th>m²</th>
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</table>

**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form.

**DATE:**

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<tr>
<th>To be given:</th>
<th>Cycle(s) #:</th>
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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:**