**DOCTOR’S ORDERS**

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

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

<table>
<thead>
<tr>
<th>DATE:</th>
<th>To be given:</th>
<th>Cycle #:</th>
</tr>
</thead>
</table>

**Date of Previous Treatment:**

**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:**

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*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.*