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

# PROTOCOL CODE: BRAJZOL5



## 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 or equal to 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** (select one)

IV in 100 mL NS over 15 min every 24 weeks x ☐ 1 or ☐ 2 (select one) treatments.

* see protocol for dose modification guidelines for renal insufficiency

## RETURN APPOINTMENT ORDERS

| | |
|---|---|
| Return in ☐ 24 or ☐ _____ weeks (select one) for doctor and treatment.<br>Book ☐ Daycare or ☐ chemo room (select one) x ☐ **one** or ☐ **two** (select one) treatments | |
| Every treatment: **Serum Creatinine**<br><br>If clinically indicated: ☐ **Serum Calcium** ☐ **Albumin**<br>☐ **Other tests:**<br><br>☐ **Consults:**<br><br>☐ **See general orders sheet for additional requests.** | |
| **DOCTOR'S SIGNATURE:** | **SIGNATURE:**<br><br>**UC:** |