DOCTOR’S ORDERS

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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 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 6 months x _______ treatments.

* see protocol for dose modification guidelines for renal insufficiency

RETURN APPOINTMENT ORDERS

Return in six 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: __________________________