



Provincial Health Services Authority

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: BRAVLHRHAI

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: _____		
TREATMENT: Choose ONE aromatase inhibitor and ONE LHRH agonist		
<input type="checkbox"/> letrozole 2.5 mg PO daily Mitte: _____ tablets Repeat x _____		
OR		
<input type="checkbox"/> anastrozole 1 mg PO daily Mitte: _____ tablets Repeat x _____		
OR		
<input type="checkbox"/> exemestane 25 mg PO daily Mitte: _____ tablets Repeat x _____		
PLUS		
buserelin long acting (SUPREFACT DEPOT)	<input type="checkbox"/> 6.3 mg subcutaneous every 6 weeks x 2 treatments <input type="checkbox"/> 6.3 mg subcutaneous every 8 weeks x _____ treatments <input type="checkbox"/> 9.45 mg subcutaneous every 12 weeks x _____ treatments	
OR		
goserelin long acting (ZOLADEX)	<input type="checkbox"/> 3.6 mg subcutaneous every 4 weeks x _____ treatments	
goserelin long acting (ZOLADEX LA)	<input type="checkbox"/> 10.8 mg subcutaneous every 12 weeks x _____ treatments	
OR		
leuprolide long acting (LUPRON DEPOT)	<input type="checkbox"/> 7.5 mg IM every 4 weeks x _____ treatments <input type="checkbox"/> 22.5 mg IM every 12 weeks x _____ treatments	
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in _____ weeks.		
If clinically indicated: <input type="checkbox"/> serum cholesterol <input type="checkbox"/> triglycerides		
<input type="checkbox"/> Other tests:		
<input type="checkbox"/> Consults:		
<input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:	SIGNATURE:	
	UC:	