PROTOCOL CODE: BRAVLHRHT (PO)

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:

Start on _____ (date)

tamoxifen 20 mg PO daily. Mitte: _____ tablets. Repeat x _____

buserelin long acting (SUPREFACT DEPOT)
- ☐ **6.3 mg** subcutaneous every 8 weeks x _____ treatments
- ☐ **9.45 mg** subcutaneous every 12 weeks x _____treatments

OR

goserelin long acting (ZOLADEX)
- ☐ **3.6 mg** subcutaneous every 4 weeks x _____treatments

goserelin long acting (ZOLADEX LA)
- ☐ **10.8 mg** subcutaneous every 12 weeks x _____treatments

OR

leuprolide long acting (LUPRON DEPOT)
- ☐ **7.5 mg** IM every 4 weeks x _____treatments
- ☐ **22.5 mg** IM every 12 weeks x _____treatments

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor.

If clinically indicated:

☐ Serum Calcium and Albumin ☐ Bilirubin ☐ GGT ☐ ALT ☐ LDH ☐ Alk Phos

☐ Creatinine ☐ CA 15-3

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: