# 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 6 weeks x 2 treatments
- ☐ **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: