### DOCTOR'S ORDERS

<table>
<thead>
<tr>
<th>Ht</th>
<th>Wt</th>
<th>BSA</th>
</tr>
</thead>
</table>

**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form.

**DATE:**

**To be given:**

**Cycle #:**

**Date of Previous Treatment:**

**TREATMENT:**

**pamidronate 90 mg** IV in 250 mL NS over 1 hour every month x _______ treatments.

### RETURN APPOINTMENT ORDERS

Return in **one** or **three** months (circle one) for doctor and treatment.

Book Daycare x **one** or **three** treatments (circle one)

Every third treatment: **Serum Creatinine**

If clinically indicated: [ ] **Serum Calcium**  [ ] **Albumin**

[ ] **Other tests:**

[ ] **Consults:**

[ ] **See general orders sheet for additional requests.**

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**

---

*PROTOCOL CODE: BRAVPAM*