

PROTOCOL CODE: BRAJZOL2

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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:	To be given:	Cycle(s) #:			
Date of Previous Treatment: _____					
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> Creatinine day of treatment May proceed with doses as written if within 28 days creatinine clearance greater than or equal to 60 mL/minute . Dose modification for: <input type="checkbox"/> Renal dysfunction <input type="checkbox"/> Other Toxicity _____ _____ Proceed with treatment based on blood work from _____					
TREATMENT:					
zoledronic acid 4 mg					
<input type="checkbox"/> Dose Modification*: <input type="checkbox"/> 3.5 mg OR <input type="checkbox"/> 3.3 mg OR <input type="checkbox"/> 3 mg (select one)					
IV in 100 mL NS over 15 min every 12 weeks x _____ treatments.					
* see protocol for dose modification guidelines for renal dysfunction					
RETURN APPOINTMENT ORDERS					
Return in <input type="checkbox"/> twelve or <input type="checkbox"/> _____ weeks (select one) for doctor and treatment.					
Book <input type="checkbox"/> Daycare or <input type="checkbox"/> chemo room (select one) x <input type="checkbox"/> one or <input type="checkbox"/> three treatments (select one)					
Creatinine prior to each treatment					
If clinically indicated: <input type="checkbox"/> calcium <input type="checkbox"/> albumin <input type="checkbox"/> ionized calcium					
<input type="checkbox"/> Other tests:					
<input type="checkbox"/> Consults:					
<input type="checkbox"/> See general orders sheet for additional requests.					
DOCTOR'S SIGNATURE:					SIGNATURE:
					UC: