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: BRAJLHRHT

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:

tamoxifen 20 mg PO daily

Mitte: ______________________**tablets** **Repeat x** __________

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 ____________ months.

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: