



Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BCCA treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care.

PROTOCOL CODE: **ULUAVGEF (PO)**

A BCCA "Compassionate Access Program" request form must be completed and approved prior to treatment

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 #:
Date of Previous Cycle:				
TREATMENT:				
Gefitinib 250 mg PO daily				
mitte _____ Repeat x _____				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in _____ weeks for Doctor				
Alk Phos, AST, Bili two weeks after starting treatment and prior to each doctor's appointment				
<input type="checkbox"/> Other tests:				
<input type="checkbox"/> Consults:				
<input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:			SIGNATURE:	
			UC:	