



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: GUKIFN

For other indications, a BCCA "Compassionate Access Program" request form must be approved prior to use.

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: _____		
Dose modification for: <input type="checkbox"/> Toxicity: _____		
TREATMENT:		
Alpha-Interferon 5 million units SC x 2 doses on _____ and _____, then Alpha-Interferon 10 million units or _____ million units SC 3 times a week (M, W, F)		
Mitte _____ month		
Repeat x _____		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in _____ weeks for Doctor.		
CBC & Diff, Platelets at Weeks 2, 4, 8 and 12. <input type="checkbox"/> AST, Bilirubin and Serum Creatinine at Weeks 2, 4, 8 and 12 if abnormal at baseline <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:	SIGNATURE:	
	UC:	