**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
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**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

**DATE:**

**To be given:**

**Cycle #:**

**Date of Previous Cycle:**

- [ ] Delay treatment ______ week(s)
- [ ] CBC & Diff, platelets, creatinine day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/L, Creatinine Clearance greater than or equal to 50 mL/min.**

Dose modification for:

- [ ] Age/ECOG
- [ ] Hematology
- [ ] Other Toxicity

Proceed with treatment based on blood work from

**CHEMOTHERAPY:**

capcitabine 1000 mg/m² or _________ mg/m² x BSA x (_______ %) = _________mg PO BID with food x 14 days on Days 1 to 14. (Round dose to nearest 150 mg).

**RETURN APPOINTMENT ORDERS**

- [ ] Return in three weeks for Doctor and Cycle _________
- [ ] Last Cycle. RTC in _________ week(s).

CBC & Diff, Platelets, Creatinine prior to each cycle.

- [ ] Tot. Prot
- [ ] Albumin
- [ ] Bilirubin
- [ ] GGT
- [ ] Alk Phos.
- [ ] ALT
- [ ] LDH
- [ ] BUN

- Other tests:

- Consists:

- See general orders sheet for further orders

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**