**DOCTOR’S ORDERS**

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<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 #:

- Delay treatment ______ week(s)
- CBC & Diff, Platelets day of treatment

May proceed with doses as written if within 96 hours ANC greater than or equal to $1.5 \times 10^9$/L, Platelets greater than or equal to $75 \times 10^9$/L, Creatinine Clearance greater than 50 mL/min.

Dose modification for:  
- Hematology
- Other Toxicity ________________

Proceed with treatment based on blood work from ________________

**TREATMENT:**

- **capecitabine** $1000 \text{ mg/m}^2 \times \text{BSA} \times (\ldots\%) = \ldots \text{mg PO BID with food x 14 days on days 1–14. (Round dose to nearest 150 mg)}$

- **lapatinib** $1250 \text{ mg or } \ldots \text{mg PO ONCE DAILY on days 1–21 (continuously). Take at least one hour before or at least one hour after a low fat meal. (round dose to nearest 250 mg)}$

**RETURN APPOINTMENT ORDERS**

- Return in three weeks for Doctor and Cycle ________
- Last Cycle. Return in _____ week(s).

CBC & Diff, Platelets, Creatinine, bilirubin, Alk Phos, ALT prior to each cycle

- INR Weekly
- INR prior to each cycle

- Other tests:
- Consults:
- See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

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