**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>Ht</th>
<th>cm</th>
<th>Wt</th>
<th>kg</th>
<th>BSA</th>
<th>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 Treatment:**

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

**Dose modification for:**

- Hematology
- Other Toxicity ________________

**Proceed with treatment based on blood work from ________________**

**TREATMENT:**

- **testosterone enanthate 400 mg** IM every 4, 3 or 2 weeks (circle one) x ______ treatments.

- OR

- **testosterone enanthate 400 mg** OR **300 mg** OR **200 mg** (circle one) IM every 4 weeks x ______ treatments.

**RETURN APPOINTMENT ORDERS**

- Return in ______ weeks for Doctor.

**If clinically indicated:**

- Serum Calcium and Albumin
  - Alkaline Phosphatase
  - Hemoglobin

- Other tests:

- Consults:

- See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**