## DOCTOR’S ORDERS

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

### Date:

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<th>To be given:</th>
<th>Cycle #:</th>
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**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 400 mg** IM every 4, 3 or 2 weeks (circle one) x _______ treatments.
  - OR
  - **testosterone 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:**