PROTOCOL CODE: GIOCTLAR

DOCTOR'S ORDERS

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Week #:**

TREATMENT:

Select one of the following dosing intervals:

☐ **Every four weeks** **OR** ☐ **Every three weeks**

☐ **octreotide long acting 20 mg** intramuscular (deep intragluteal) injection

Mitte: _____ dose Repeat x _____

☐ **octreotide long acting 30 mg** intramuscular (deep intragluteal) injection

Mitte: _____ dose Repeat x _____

☐ **octreotide long acting ____ mg** intramuscular (deep intragluteal) injection

Mitte: _____ dose Repeat x _____

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor.

☐ **Ultrasound gallbladder** every 6 months

☐ **Other Tests:** _____

☐ **Consults:** _____

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: