**DOCTOR’S ORDERS**

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

<table>
<thead>
<tr>
<th>Date of Previous Cycle:</th>
<th>To be given:</th>
<th>Cycle #:</th>
</tr>
</thead>
</table>

- Delay treatment _____ week(s) for □ Hypertension □ Diarrhea □ Other
- □ CBC & Diff, Platelets day of treatment

May proceed with doses as written if within 96 hours ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 75 x 10^9/L, BP less than 160/100 mmHg, diarrhea less than or equal to Grade 2, creatinine clearance greater than or equal to 30 mL/min, alkaline phosphatase, ALT less than or equal to 5 X ULN, total bilirubin less than or equal to 3 X ULN, urine protein less than 1 g/24 h

Dose modification for: □ Hematology □ Hypertension □ Diarrhea □ QTc prolongation □ Other Toxicity

Proceed with treatment based on blood work from ________________________________

**CHEMOTHERAPY: One cycle = 30 days**

Treatment starting on ______________________ (date)

- □ levetiracetam 12 mg or 8 mg PO once daily. Supply for: _____________ days.
- □ levetiracetam 4 mg PO once daily. Supply for: _____________ days.
- □ levetiracetam 4 mg PO once every other day. Supply for: _____________ days.

**RETURN APPOINTMENT ORDERS**

- □ Return in _____ weeks for Doctor and Cycle ________.
- □ Please book Nurse for BP monitoring q 2 weeks x ____________.
- □ Last Cycle. Return in _____ week(s).

CBC & Diff, Platelets, Creatinine, Sodium, Potassium, Calcium, Magnesium, ALT, Alkaline phosphatase, Bilirubin, Albumin, TSH, urine protein, Blood Pressure Measurement prior to each cycle

Every two weeks for first 2 months: ALT, Alkaline phosphatase, Bilirubin, Albumin, Blood pressure

If clinically indicated: □ Urine Dipstick □ 24 hour urine protein □ total protein

□ GGT □ LDH □ BUN □ ECG □ INR □ Echocardiography □ AFP

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

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**