A BC Cancer “Compassionate Access Program” request form must be completed and approved prior to treatment.

## DOCTOR’S ORDERS

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

<table>
<thead>
<tr>
<th>DATE:</th>
<th>To be given:</th>
<th>Week #:</th>
</tr>
</thead>
</table>

### TREATMENT:

- **octreotide (SANDOSTATIN LAR) 30 mg** intramuscular (deep intragluteal) injection every 4 weeks.
  - Mitte: ________ dose  Repeat x ________

- **octreotide (SANDOSTATIN LAR) ____ mg** intramuscular (deep intragluteal) injection every 4 weeks.
  - Mitte: ________ dose  Repeat x ________

### RETURN APPOINTMENT ORDERS

- □ Return in ______ weeks for Doctor

- □ Ultrasound gallbladder

- □ Glucose

- □ CT Scan

- □ Other Tests: ____________________________

- □ Consults: ______________________________

- □ See general orders sheet for additional requests.

## DOCTOR’S SIGNATURE:

- **SIGNATURE:**

- **UC:**