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

**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA 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 Cycle: ____________________________

- ☐ Delay treatment _____ week(s)
- ☐ 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 10⁹/L, Platelets greater than or equal to 50 x 10⁹/L, BP less than 160/100 mmHg**

Dose modification for:
- ☐ Hematology
- ☐ Other Toxicity: ____________________________

Proceed with treatment based on blood work from ____________________________

**CHEMOTHERAPY: One Cycle = 4 weeks**

Treatment starting on ____________________________

- ☐ regorafenib 160 mg PO daily for 21 days followed by 7 days rest.
- ☐ regorafenib 120 mg PO daily for 21 days followed by 7 days rest.
- ☐ regorafenib 80 mg PO daily for 21 days followed by 7 days rest.

Supply for: ____________________________

**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, Phosphate, Bilirubin, Alkaline Phosphatase, ALT, Urinalysis, Blood Pressure Measurement** prior to each cycle

- ☐ TSH prior to each odd numbered cycle (ie 3, 5, 7, 9, etc)

If clinically indicated:
- ☐ GGT
- ☐ LDH
- ☐ Tot. Prot
- ☐ Albumin
- ☐ TSH
- ☐ AFP
- ☐ MUGA scan or ☐ Echocardiography
- ☐ ECG

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

**DOCTOR’S SIGNATURE:** ____________________________

**SIGNATURE:** ____________________________

**UC:** ____________________________