**DOCTOR’S ORDERS**

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

Continuous treatment, one cycle consists of 4 weeks of SORAfenib

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

- 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 10^9/L, Platelets greater than or equal to 50 x 10^9/L**

Dose modification for:  
- **Hematology**
- **Other Toxicity**

Proceed with treatment based on blood work from ________________________________

**CHEMOTHERAPY: One cycle = 4 weeks**

Treatment starting on __________________________ (date)

- SORAfenib 400 mg PO **twice** daily. Supply for: _____________ days.
- SORAfenib 400 mg PO **once** daily. Supply for: _____________ days (dose level -1)
- SORAfenib 400 mg PO **once every other day**. Supply for: _____________ days (dose level -2)
- SORAfenib 200 mg PO **once or twice daily**. *(circle one)* 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, ALT, Bilirubin prior to each cycle

- Sodium
- Potassium
- Magnesium
- Calcium
- Phosphate
- Albumin
- Lipase
- Amylase
- TSH
- INR
- AFP
- MUGA scan or □ Echocardiography □ ECG (if clinically indicated)

Imaging (appr. every 8 weeks):

- Other tests:
- Consults:

See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:** □

**SIGNATURE:** □

**UC:** □