**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:**

May proceed with doses as written if within 24 hours (for first treatment) or 7 days (for subsequent prescriptions) **ANC greater than or equal to** $0.8 \times 10^9/\text{L}$, fasting triglycerides **less than or equal to** 3.5 mmol/L and ALT and bilirubin **less than or equal to** 3 times the upper limit of normal range.

**Dose modification for:**

- [ ] Hematology
- [ ] Other Toxicity: ____________________________

**TREATMENT:**

bexarotene 300 mg/m²/day OR 400 mg/m²/day OR 200 mg/m²/day (circle one) = _________ mg PO once daily with a meal. (round off to nearest 75 mg)

Mitte: __________ months

**RETURN APPOINTMENT ORDERS**

- [ ] Return in **eight** weeks for Doctor.
- [ ] Return in _____ week(s).

CBC & Diff, Platelets, ALT, Bilirubin, Fasting Triglycerides, TSH and T4 every two months.

ALT, Bilirubin and Fasting Triglycerides weekly after initiating treatment (until stabilization – usually first 2-4 weeks)

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

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**