**DOCTOR'S ORDERS**

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form One cycle = 6 weeks

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

Date of Previous Cycle:
- [ ] Delay treatment ______ week(s)
- [ ] CBC & Diff, Platelets day of treatment

May proceed with doses as written if within 48 hours **ANC greater than or equal to** $1.0 \times 10^9/L$, Platelets **greater than or equal to** $100 \times 10^9/L$

Dose modification for:  
- [ ] Hematology
- [ ] Other Toxicity ____________________________

Proceed with treatment based on blood work from ____________________________

**CHEMOTHERAPY:**
- [ ] SUNItinib 50 mg or _______ mg PO once daily for 4 weeks followed by 2 weeks rest. Mitte: _______ capsules. OR
- [ ] SUNItinib 37.5 mg or _______ mg PO once daily continuously. Mitte: _______ capsules.

**RETURN APPOINTMENT ORDERS**

- [ ] Return in _______ weeks for Doctor and Cycle ________.
- [ ] Last Cycle. Return in _______ week(s).

CBC & Diff, Platelets, Creatinine, ALT, Bill, Urinalysis, uric acid prior to each cycle.

- [ ] TSH prior to every other cycle (i.e. 1, 3, 5, 7, 9, etc.)

If clinically indicated:  
- [ ] Tot. Prot
- [ ] Albumin
- [ ] GGT
- [ ] Alk Phos.
- [ ] LDH
- [ ] TSH
- [ ] Calcium
- [ ] Phos.
- [ ] Potassium

- [ ] MUGA scan or [ ] Echocardiography (if clinically indicated)

- [ ] Other Tests: ____________________________

- [ ] Consults: ____________________________

- [ ] See general orders sheet for additional requests.

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**