PROTOCOL CODE: GUOTSUNI

DOCTOR'S ORDERS

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** 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 75 x 10^9/L**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____

Proceed with treatment based on blood work from _____

TREATMENT:

☐ **SUNItinib** ☐ **50 mg or** ☐ **_____mg** (select one) PO once daily for 4 weeks followed by 2 weeks rest.

Dispense: _____ days.

OR

☐ **SUNItinib** ☐ **37.5 mg or** ☐ **_____mg** (select one) PO once daily continuously. Dispense: _____ days.

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor and Cycle _____.
☐ Last Cycle. Return in _____ week(s).

Prior to Cycle 2**: CBC & Diff, creatinine, total bilirubin, ALT, albumin, random glucose, sodium, potassium, magnesium, phosphate, calcium**

Prior to Cycle 3 and onwards**: CBC & Diff, creatinine, total bilirubin, ALT, random glucose, sodium, potassium**

If clinically indicated:

☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **TSH** ☐ **magnesium** ☐ **calcium**
☐ **phosphate** ☐ **24-hour urine metanephrines and catecholamines**
☐ **dipstick or laboratory urinalysis for protein**
☐ **24-hour urine protein within 3 days prior to next cycle if laboratory urinalysis for protein greater than or equal to 1 g/L or dipstick proteinuria 2+ or 3+**
☐ **ECG** ☐ **MUGA scan or** ☐ **echocardiogram**
☐ **Other tests:**
☐ **Weekly nursing assessment for (specify concern): _____**
☐ **Consults:**
☐ **See general orders sheet for additional requests**

DOCTOR'S SIGNATURE:

SIGNATURE:

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