PROTOCOL CODE: GIPNSUNI

DOCTOR'S ORDERS

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form
One cycle = 4 weeks

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 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 _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.
☐ **ondansetron 8 mg** po
☐ **dexamethasone 8 mg** po
☐ **Other:**

CHEMOTHERAPY:

☐ **SUNItinib 37.5 mg** PO once daily continuously. Mitte: _____ days.
☐ **SUNItinib 25 mg** PO once daily continuously. Mitte: _____ days. (dose level -1)
☐ **SUNItinib 50 mg** PO once daily continuously. Mitte: _____ days. (dose level +1)

RETURN APPOINTMENT ORDERS

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

CBC & Diff, Platelets, Creatinine, ALT, Bili, Urinalysis, uric acid prior to each cycle
☐ **TSH** prior to every other cycle (i.e., cycle 1, 3, 5, 7, 9, etc.)

If clinically indicated: ☐ **Tot. Prot** ☐ **Albumin** ☐ **GGT** ☐ **Alk Phos.**
☐ **LDH** ☐ **TSH** ☐ **Calcium** ☐ **Phos.**
☐ **sodium** ☐ **potassium** ☐ **Random Glucose**

☐ **MUGA scan or** ☐ **Echocardiography (if clinically indicated)**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: