DOCTOR'S ORDERS

Ht_____cm Wt_____kg BSA_____m^2

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

DATE:

TREATMENT:

Treatment starting on _____ (date)

tamoxifen 10 mg PO every other day. Mitte: _____ tablets. Repeat x _____

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor.

If clinically indicated:

- ☐ **CBC & Diff, platelets**
- ☐ **serum cholesterol**
- ☐ **triglycerides**
- ☐ **total bilirubin**
- ☐ **alkaline phosphatase**
- ☐ **ALT**
- ☐ **GGT**

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: