

Name: _____

HCN: _____

Date of Birth: _____



CC 3130 0124 07 2020

Weight: _____ kg Height: _____ cm Body Surface Area (BSA) = _____

Allergies: No Known

Date: DD/MONTH/YYYY Planned Administration Date: DD/MONTH/YYYY
 Cycle _____ of _____ **Cycle Duration: 28 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** $1.5 \times 10^9/L$ and platelets **greater than or equal to** $100 \times 10^9/L$, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Blood pressure assessed.
- Proteinuria assessed.
- Toxicities recovered to less than or equal to grade 2

PREMEDICATIONS: None recommended

Other: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

aXitinib 7 mg
PO bid

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.