**DOCTOR’S ORDERS**

| Ht________cm | Wt________kg | BSA________m² |

**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, platelets day of treatment |

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.5 x 10⁹/L,**

**Platelets greater than 90 x 10⁹/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 __________.

Select ONE of the following routine antiemetics regimens:

- [ ] ondansetron 8 mg PO 30 to 60 minutes prior to AC treatment
- [ ] dexamethasone 8 mg or 12 mg (circle one) PO 30 to 60 minutes prior to AC treatment
- [ ] netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to AC treatment
- [ ] dexamethasone 8 mg or 12 mg (circle one) PO 30 to 60 minutes prior to AC treatment

As needed antiemetics:

- [ ] prochlorperazine 10 mg PO prn
- [ ] metoclopramide 10 mg PO prn

**OR**  
45 Minutes Prior to PACLitaxel: **dexamethasone 20 mg** IV in NS 50 mL over 15 minutes  
30 Minutes Prior to PACLitaxel: **diphenhydRAMINE 50 mg** IV and **ranitidine 50 mg** IV in NS 50 mL over 20 minutes (compatible up to 3 hrs when mixed in bag)

**Other:**

**Chemotherapy:**

**DOXorubicin 60 mg/m² x BSA = __________mg**

- [ ] Dose Modification: __________% = __________ mg/m² x BSA = __________ mg

**cyclophosphamide 600 mg/m² x BSA = __________mg**

- [ ] Dose Modification: __________% = __________ mg/m² x BSA = __________ mg

IV in NS 100 to 250 mL over 20 minutes to 1 hour

**OR**

**PACLitaxel 175 mg/m² OR 150 mg/m² (circle one) x BSA = __________mg**

- [ ] Dose Modification: __________% = __________ mg/m² x BSA = __________ mg

IV in NS 500 mL (non-DEHP bag) over 3 hours (use non-DEHP tubing with 0.22 micron or smaller in-line filter.)

**RETURN APPOINTMENT ORDERS**

| □ Return in three weeks for Doctor and Cycle __________ |
| □ Last Cycle. Return in __________ week(s) |

**CBC & Diff, Platelets prior to each cycle**

- [ ] Bilirubin, ALT, prior to next treatment.

If clinically indicated:  

- [ ] Creatinine
- [ ] ALT
- [ ] Bilirubin
- [ ] Muga Scan
- [ ] Echocardiogram

**Other tests:**

**Consults:**

See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**

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**BC Cancer Provincial Preprinted Order BRAJACT**

**Created:** April 4th, 2005  
**Revised:** 1 Mar 2020