**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 on 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 or equal to 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

- [ ] Other

**CHEMOTHERAPY:**

**DOXOrubicin 60 mg/m² x BSA = _________ mg**

- [ ] Dose Modification: ________% = ________ mg/m² x BSA = _________ mg  
  - IV push

**Cyclophosphamide 600 mg/m² x BSA = _________ mg**

- [ ] Dose Modification: ________% = ________ mg/m² x BSA = _________ mg  
  - IV in 100 to 250 mL NS over 20 minutes to 1 hour

**RETURN APPOINTMENT ORDERS**

- [ ] Return in **three** weeks for Doctor and Cycle

- [ ] Last Cycle. Return in __________ week(s)

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

If clinically indicated:  
- [ ] Creatinine  
- [ ] Bilirubin

- [ ] Other tests:

- [ ] Consults:

- [ ] See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**