**DOCTOR'S ORDERS**

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
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**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 or equal to 100 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 treatment
- ☐ dexamethasone 8 mg or 12 mg (circle one) PO 30 to 60 minutes prior to treatment
- ☐ netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to treatment
- ☐ dexamethasone 8 mg or 12 mg (circle one) PO 30 to 60 minutes prior to treatment

- ☐ prochlorperazine 10 mg PO prn
- ☐ metoclopramide 10 mg PO prn
- ☐ hydrocortisone 100 mg IV PRN

For DOCEtaxel cycles: Dexamethasone 8 mg PO bid for 3 days starting one day prior to DOCEtaxel. Patient must receive 3 doses prior to treatment.

- Optional: Frozen gloves starting 15 minutes before DOCEtaxel infusion until 15 minutes after end of DOCEtaxel infusion; gloves should be changed after 45 minutes of wearing.

- ☐ Other:

  ** Have Hypersensitivity Reaction Tray and Protocol Available**

**CHEMOTHERAPY:**

- epirubicin 100 mg/m² x BSA = ________ mg
  - ☐ Dose Modification: ________% = ________ mg/m² x BSA = ________ mg
  - IV push

- fluorouracil 500 mg/m² x BSA x = ________ mg
  - ☐ Dose Modification: ________% = ________ mg/m² x BSA = ________ mg
  - IV push

- cyclophosphamide 500 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

OR

- DOCEtaxel 100 mg/m² x BSA = ________ mg
  - ☐ Dose Modification: ________% = ________ mg/m² x BSA = ________ mg
  - IV in 250 to 500 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing)

**RETURN APPOINTMENT ORDERS**

- ☐ Return in three weeks for Doctor and Cycle ________
- ☐ Last Cycle. Return in ______ week(s).

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

Prior to **Cycle 4:** Bilirubin, Alk Phos, ALT

If clinically indicated: ☐ Bilirubin ☐ Creatinine ☐ Tot. Prot ☐ Albumin

☐ GGT ☐ LDH ☐ ALT ☐ Alk Phos ☐ BUN ☐ Muga Scan

☐ Echocardiogram

☐ Other tests:

☐ Consults:

☐ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

| SIGNATURE: |
| UC: |