**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

As needed:

- [ ] prochlorperazine 10 mg PO prn
- [ ] metoclopramide 10 mg PO prn
- [ ] hydrocortisone 100 mg IV PRN

**CHEMOTHERAPY:**

**epirubicin 100 mg/m² x BSA = __________mg**

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

**fluorouracil 500 mg/m² x BSA = __________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

**RETURN APPOINTMENT ORDERS**

- [ ] Return in three weeks for Doctor and Cycle __________
- [ ] Last Cycle. Return in __________ weeks.

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

If clinically indicated: [ ] Bilirubin  [ ] Creatinine  [ ] Muga Scan  [ ] Echocardiogram

- [ ] Other tests:

- [ ] Consults:

- [ ] See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURES:**

**UC:**