PROTOCOL CODE: BRAJPN

DOCTOR'S ORDERS

Ht_____cm Wt_____kg BSA_____m^2

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #:**

Date of Previous Cycle:

Number of PACLitaxel or DOCEtaxel cycles completed to date: _____

☐ 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 10^9/L, Platelets greater than or equal to 100 x 10^9/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 _____.

☐ **Other:**

CHEMOTHERAPY:

PACLitaxel NAB (ABRAXANE) 260 mg/m^2 x BSA = _____mg

☐ Dose Modification: _____mg/m^2 x BSA = _____mg

IV over 30 minutes (in empty sterile PVC, non-PVC or non-DEHP bag and tubing; use tubing with **15** micron filter)

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____

☐ Last Cycle. Return in _____weeks.

CBC & Diff, Platelets prior to each cycle (bilirubin, ALT, GGT, LDH, alkaline phosphatase, creatinine required prior to Cycle 1)

If clinically indicated: ☐ **Bilirubin** ☐ **Alk Phos** ☐ **ALT** ☐ **GGT**
☐ **Creatinine** ☐ **BUN**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: