### DOCTOR’S ORDERS

<table>
<thead>
<tr>
<th>Ht</th>
<th>cm</th>
<th>Wt</th>
<th>kg</th>
<th>BSA</th>
<th>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, and Creatinine day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.0 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/L, Creatinine Clearance greater than 50 mL/min.**

Dose modification for:

- □ Age /ECOG
- □ Hematology
- □ Other Toxicity

Proceed with treatment based on blood work from __________________________________________________________________________

### CHEMOTHERAPY:

**capecitabine 1250 mg/m² or 1000 mg/m²** (circle one) x BSA x (______%) = _______mg PO BID with food x 14 days on days 1 –14. (Round dose to nearest 150 mg)

### RETURN APPOINTMENT ORDERS

- □ Return in **three** weeks for Doctor and Cycle _________
- □ Last Cycle. Return in _____ weeks.

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

If clinically indicated:

- □ Tot. Prot
- □ Albumin
- □ Bilirubin
- □ GGT
- □ Alk Phos.
- □ LDH
- □ ALT
- □ BUN
- □ CA 15-3

- □ Other tests:

- □ Consults:

- □ See general orders sheet for further orders

### DOCTOR’S SIGNATURE:

**SIGNATURE:**

**UC:**