**PROTOCOL CODE: BRAVDOC**

### 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 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 __________________

- Dexamethasone 8 mg PO BID for 3 days, starting one day prior to treatment. 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.

**Have Hypersensitivity Reaction Tray and Protocol Available**

**CHEMOTHERAPY:**

- **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. RTC in __________ weeks.

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

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

If Clinically Indicated:

- □ Tot. Prot  □ Albumin  □ Bilirubin  □ GGT  □ Alk Phos.
- □ AST  □ LDH  □ ALT  □ BUN  □ Creatinine

- □ Other tests:
- □ Consults:
- □ See general orders sheet for further orders

**DOCTOR'S SIGNATURE:**

SIGNATURE:

UC: