## 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 24 hours ANC greater than or equal to \(1.0 \times 10^9/L\), Platelets greater than or equal to \(75 \times 10^9/L\)
  - Dose modification for: [ ] Hematology [ ] Renal Function [ ] Other Toxicity
  - Proceed with treatment based on blood work from

### PREMEDICATIONS:
- Patient to take own supply. RN/Pharmacist to confirm __________________________.
- [ ] prochlorperazine 10 mg PO prior to treatment
- [ ] metoclopramide 10 to 20 mg PO prior to treatment
- [ ] Other:

### CHEMOTHERAPY:
**DAY 1 and 8**

- eriBULin 1.4 mg/m²/day x BSA = _________mg
  - [ ] Dose Modification: ______% = _______ mg/m²/day x BSA = _________ mg
  - IV Push over 2 to 5 minutes on Day 1 and Day 8.

**OR**

- Dose Modification REQUIRED ON DAY 8

  - eriBULin 1.4 mg/m²/day x BSA = _________mg
  - [ ] Dose Modification: ______% = _______ mg/m²/day x BSA = _________ mg
  - IV Push over 2 to 5 minutes on Day _______________

### RETURN APPOINTMENT ORDERS

- [ ] Return in three weeks for Doctor and Cycle____. Book chemo room Day 1 and Day 8*
- [ ] Last Cycle. Return in _______weeks.

* if day 8 treatment given on day 15, start of next cycle is 2 weeks from day 15

**CBC & Diff, platelets, sodium, potassium, Creatinine, bilirubin, GGT, alk phos, ALT, LDH prior to Day 1**

**CBC & Diff, platelets, Creatinine prior to Day 8**

If clinically indicated:

- [ ] Total Protein [ ] Albumin [ ] BUN

- [ ] Other Tests:
- [ ] Consults:
- [ ] See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**