### 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 day of treatment

May proceed with doses as written Day 1 if within 96 hours ANC *greater than or equal to* 1.5 x 10⁹/L, Platelets *greater than* 100 x 10⁹/L

May proceed with doses as written Day 8 if within 48 hours ANC *greater than or equal to* 1.2 x 10⁹/L, Platelets *greater than* 75 x 10⁹/L

Dose modification for:  
- [ ] Hematology
- [ ] Other Toxicity

Proceed with treatment based on bloodwork from _______________________

**PREMEDICATIONS:**

Patient to take own supply. RN/Pharmacist to confirm

dexamethasone 8 mg PO BID for 3 days, starting one day prior to DOCEtaxel 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.

- [ ] Other:

**CHEMOTHERAPY:**

- **DOCEtaxel** 75 mg/m² x BSA = _______mg
  - [ ] Dose Modification: ________% = ________ mg/m² x BSA = ________ mg
  - IV in 100 to 500 mL NS (use non-DEHP bag) over 1 hour *Day 1 only.* (Use non DEHP tubing)

- **gemcitabine** 1000 mg/m² x BSA = _______ mg
  - [ ] Dose Modification: ________% = ________ mg/m² x BSA = ________ mg
  - IV in 250 mL NS over 30 minutes *Day 1 and 8*

**DOSE MODIFICATION IF REQUIRED ON DAY 8:**

- **gemcitabine** 1000 mg/m² x BSA = _______ mg
  - [ ] Dose Modification: ________% = ________ mg/m² x BSA = ________ mg
  - IV in 250 mL NS over 30 minutes on *Day 8*

**RETURN APPOINTMENT ORDERS**

- [ ] Return in **three** weeks for Doctor and Cycle _____. Book Chemo room Day 1 & 8.
- [ ] Last Cycle. Return in ____________ weeks.

CBC & Diff, Platelets prior to each cycle (Day 1 and 8)

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

If clinically indicated:

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

- [ ] Other tests:
- [ ] Consults:

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**