**PROTOCOL CODE: BRAVGEM**

**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>Ht</th>
<th>Wt</th>
<th>BSA</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 x 10^9/L, **Platelets greater than or equal to** 90 x 10^9/L

Dose modification for: [ ] Hematology [ ] Other Toxicity

Proceed with treatment based on blood work from ______________________________________________________________________

**PREMEDICATIONS:**

- [ ] Prochlorperazine 10 mg PO prior to treatment
- [ ] Metoclopramide 10 mg PO prior to treatment
- [ ] Other:

**CHEMOTHERAPY:**

Gemcitabine 800 mg/m² x BSA = ________ mg

- [ ] Dose Modification: ________% = ________ mg/m² x BSA = ________ mg

IV in 250 mL NS over 30 minutes on **Day 1, 8 and 15.**

**DOSE MODIFICATION (If required for Day 8 and/or 15)**

Day 8 and 15 **OR** Day 15 (circle one)

Gemcitabine 800 mg/m² x BSA = ________ mg

- [ ] Dose Modification: ________% = ________ mg/m² x BSA = ________ mg

IV in 250 mL NS over 30 minutes.

**RETURN APPOINTMENT ORDERS**

- [ ] Return in four weeks for Doctor and Cycle _____. Book chemo Day 1, 8 and 15.
- [ ] Last Cycle. Return in ____________ weeks.

- [ ] CBC & Diff, Platelets prior to each treatment
- [ ] Other tests:
- [ ] Consults:
- [ ] See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

SIGNATURE:

UC: