## DOCTOR’S ORDERS

<table>
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<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 96 hours **ANC greater than or equal to 1.5 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:

**45 minutes prior to PACLitaxel:**
- dexamethasone 20 mg IV in 50 mL NS over 15 minutes.

**30 minutes prior to PACLitaxel:**
- diphenhydrAMINE 50 mg IV and ranitidine 50 mg IV in 50 mL NS over 20 minutes.
  (compatible up to 3 hours when mixed in a bag)
- **Other:**

  **Have Hypersensitivity Reaction Tray and Protocol Available**

### CHEMOTHERAPY:

**PACLitaxel 175 mg/m^2 x BSA = _________ mg**
- **Dose Modification:** _________ mg/m^2 x BSA = _________ mg
  IV in 250 to 500 mL (use non-DEHP bag) NS over 3 hours. (Use non DEHP tubing with 0.22 micron or smaller in-line filter)

### RETURN APPOINTMENT ORDERS

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

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

If clinically indicated: **Bilirubin** **ALT**

**Other tests:**
- **Consults:**
- **See general orders sheet for additional requests.**

### DOCTOR’S SIGNATURE:

**SIGNATURE:**

**UC:**