### 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(s) of treatment

May proceed with doses as written if within 24h (for paclitaxel) or 96h (AC) ANC greater than or equal to $1.5 \times 10^9/L$, Platelets greater than or equal to $90 \times 10^9/L$.

Dose modification for:

- ☐ Hematology
- ☐ Other Toxicity ________________

Proceed with treatment based on blood work from ________________

**PREMEDICATIONS:** Patient to take own supply. RN/Pharmacist to confirm ________________.

45 Minutes Prior to PACLitaxel:  
- dexamethasone 10 mg IV in 50 mL NS over 15 minutes

30 Minutes Prior to PACLitaxel:  
- diphenhydrAMINE 25 mg IV and ranitidine 50 mg IV in 50 mL NS over 20 minutes (compatible up to 3 hrs when mixed in bag)

- ☐ No pre-medication required (see protocol for guidelines)

**OR**

- ondansetron 8 mg PO prior to AC treatment

- dexamethasone 8 mg or 12 mg (circle one) PO prior to AC treatment

- ☐ aprepitant 125 mg PO pre-chemotherapy on Day 1 and 80 mg PO post-chemotherapy once daily on Days 2 and 3

- ☐ prochlorperazine 10 mg PO prn

- ☐ metoclopramide 10 mg PO prn

**CHEMOTHERAPY:** (Note – continued over 2 pages)

- ☐ CYCLE #__________ (Cycle 1-4)

PACLitaxel 80 mg/m² OR ________ mg/m² (circle one) x BSA = ________ mg

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

IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour once weekly x 3 weeks (use non-DEHP tubing with 0.22 micron or smaller in-line filter)

**SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 5 TO 8**

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**
**DATE:**

To be given: 

Cycle #: 

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**CHEMOTHERAPY continued**

- **DOXOrubicin 60 mg/m² x BSA = ________ mg**
  - Dose Modification: ________% = ________ mg/m² x BSA = ________ mg
  - IV push

- **cyclophosphamid 600 mg/m² x BSA = ________ mg**
  - Dose Modification: ________% = ________ mg/m² x BSA = ________ mg
  - IV in 100 to 250 mL NS over 20 minutes to 1 hour

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**RETURN APPOINTMENT ORDERS**

- **Return in three weeks for Doctor and Cycle ___________ (Book chemo room weekly x 3 for cycles 1-4, book chemo room every 3 weeks for AC cycles 5-8, cycle 5 to start week 13)**

- **Last Cycle. Return in ________________ week(s) after last treatment.**

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

- If clinically indicated:  
  - □ Creatinine  
  - □ ALT  
  - □ Bilirubin  
  - □ Muga  
  - □ Echocardiogram

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**Other tests:**

- □ Consults:

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**See general orders sheet for additional requests.**

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**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**