**DOCTOR'S ORDERS**

<table>
<thead>
<tr>
<th>Ht</th>
<th>Wt</th>
<th>BSA</th>
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REMEMBER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form.

**DATE:**

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<th>To be given:</th>
<th>Cycle #:</th>
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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 100 x 10^9/L, Alk Phos less than **2.5 x ULN** and AST or ALT less than or equal to **1.5 x ULN**.

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

Proceed with treatment based on blood work from ____________________________

**PREMEDICATIONS:**

Patient to take own supply. RN/Pharmacist to confirm ____________________________

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

****Have Hypersensitivity Reaction Tray and Protocol Available**

**CHEMOTHERAPY:**

DOCEtaxel 75 mg/m² x BSA = ____________mg

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

IV in 250 to 500 mL (non-DEHP bag) NS over 1 hour (Use non-DEHP tubing)

**RETURN APPOINTMENT ORDERS**

- [ ] Return in three weeks for Doctor and Cycle _________
- [ ] Last Cycle. RTC in _________ weeks.

CBC & Diff, Platelets prior to each cycle

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

If Clinically Indicated:
- [ ] Tot. Prot
- [ ] Albumin
- [ ] Bilirubin
- [ ] GGT
- [ ] Alk Phos.
- [ ] LDH
- [ ] ALT
- [ ] BUN
- [ ] Creatinine
- [ ] CEA
- [ ] CA 19-9

- [ ] Other tests:
- [ ] Consults:
- [ ] See general orders sheet for further orders

**DOCTOR'S SIGNATURE:**

[ ] SIGNATURE:

[ ] UC: