**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>Height (cm)</th>
<th>Weight (kg)</th>
<th>Body Surface Area (m²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ht________cm</td>
<td>Wt________kg</td>
<td>BSA________m²</td>
</tr>
</tbody>
</table>

**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, creatinine, bilirubin, ALT, alk phos day of treatment

May proceed with doses as written if within 24 hours ANC greater than or equal to 1.5 x 10^9/L, platelets greater than or equal to 75 x 10^9/L, creatinine clearance greater than 50 mL/min, bilirubin less than 25 micromol/L, and ALT less than or equal to 2.5 x ULN

Dose modification for:  

- Hematology
- Other Toxicity: _____________________________

Proceed with treatment based on blood work from _____________________________

**CHEMOTHERAPY:**

- **capecitabine 750 mg/m² x BSA x ( _____ %) = _________ mg PO** bid with food **Days 1 to 14**
  
  (Total daily dose = 1500 mg/m²/day)  
  (Round dose to nearest 150 mg)

- **temozolomide 200 mg/m² or _________ mg/m² x BSA x ( ______ %) = ________mg PO** daily **Days 10 to 14**

**RETURN APPOINTMENT ORDERS**

- Return in **four** weeks for Doctor and Cycle _________
- Last Cycle. Return in ______ week(s).

CBC & diff, platelets, creatinine, bilirubin, ALT, alk phos prior to each cycle

- If clinically indicated:  
  - electrolytes
  - magnesium
  - calcium
  - glucose
  - CgA
  - 24 Hr urine 5-HIAA

- INR weekly  
- INR prior to each cycle

Other tests:

- Weekly Nursing Assessment
- Consults:

- See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**