

PROTOCOL CODE: GIA

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DOCTOR'S ORDERS		Ht _____ cm Wt _____ kg BSA _____ m ²
REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form		
DATE: _____	To be given: _____	Cycle #: _____
Date of Previous Cycle: _____		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff day of treatment May proceed with doses as written if within 96 hours ANC greater than or equal to 1.5 x 10⁹/L , platelets greater than or equal to 100 x 10⁹/L Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____		
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____. ondansetron 8 mg PO prior to treatment dexamethasone 12 mg PO prior to treatment <input type="checkbox"/> Other: _____		
CHEMOTHERAPY: DOXOrubicin 60 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV push		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Cycle. Return in _____ week(s)		
CBC & Diff, creatinine, total bilirubin, ALT, INR, albumin prior to each cycle If clinically indicated: <input type="checkbox"/> AFP <input type="checkbox"/> ECG <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> GGT <input type="checkbox"/> sodium <input type="checkbox"/> potassium <input type="checkbox"/> INR weekly <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC: