**DOCTOR’S ORDERS**

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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(s) #:

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 75 x 10^9/L, Creatinine Clearance greater than 50 mL/min**

Dose modification for:  
- [ ] Hematology
- [ ] Age greater than or equal to 65
- [ ] 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** 8 mg or 12 mg (circle one) PO prior to treatment
- [ ] Prophylactic atropine 0.3 mg SC
- [ ] Other: ____________________________

**CHEMOTHERAPY:**

- [ ] Repeat in three weeks

  - Irinotecan 200 mg/m^2 x BSA = ________ mg
  - [ ] Dose Modification: ________ mg/m^2 x BSA = ________ mg
  - IV in 500 mL D5W over 1 hour 30 minutes

  - Capecitabine 800 mg/m^2 or ________ x BSA X (______%) = ________ mg PO bid with food x 14 days
  - (Round dose to nearest 150 mg)

**Counsel patient** to obtain supply of loperamide and take 4 mg PO at first onset of diarrhea and then 2 mg PO q 2 h until diarrhea free x 12 hours (may take 4 mg PO q 4 h during the night).

- Atropine 0.3 to 0.6 mg SC prn repeat up to 1.2 mg for early diarrhea, abdominal cramps, rhinitis, lacrimation, diaphoresis or flushing.

**RETURN APPOINTMENT ORDERS**

- [ ] Return in **three** weeks for Doctor and Cycle ________
- [ ] Return in **six** weeks for Doctor and Cycle _____ & _______. Book chemo x 2 cycles
- [ ] Last Cycle. Return in ________ week(s)

**CBC & Diff, Platelets, Creatinine, Bili, ALT, Alk Phos** prior to each cycle

- [ ] INR weekly
- [ ] INR prior to each cycle
- [ ] CEA
- [ ] CA19-9

- [ ] Other tests:
- [ ] Weekly Nursing Assessment
- [ ] Consults:
- [ ] See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**