## DOCTOR’S ORDERS

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
</tr>
</thead>
</table>

**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

**DATE:**

<table>
<thead>
<tr>
<th>To be given:</th>
<th>Cycle(s) #:</th>
</tr>
</thead>
</table>

**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** 1.2 x 10⁹/L, **Platelets greater than or equal to** 75 x 10⁹/L, Creatinine Clearance **greater than or equal to** 50 mL/minute, **BP less than or equal to** 160/100. For those patients on warfarin, **hold bevacizumab if INR greater than** 3.0

Dose modification for:  

- [ ] Hematology
- [ ] 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
- [ ] Other:

**CHEMOTHERAPY:**

- [ ] Repeat in three weeks

**Oxaliplatin line to be primed with D5W; bevacizumab line to be primed with NS**

**Oxaliplatin** 130 mg/m² x BSA = ________ mg

- [ ] Dose Modification: _________mg/m² x BSA = ________mg

  - IV in 250 to 500 mL D5W over 2 hours. Flush line with D5W pre and post oxaliplatin

**Bevacizumab** 7.5 mg/kg x ________ kg = ________ mg

  - IV in 100 mL NS over 15 minutes via infusion pump. Flush line with 25 mL NS pre and post bevacizumab.

  - (Blood pressure measurement pre and post dose for first 3 cycles and prior to bevacizumab for subsequent cycles)

**Capecitabine** 1000 mg/m² or ______ x BSA x (_______ %) = ________ mg PO bid with food x 14 days

  - *(Round to nearest 150 mg)*

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

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

<table>
<thead>
<tr>
<th>RETURN APPOINTMENT ORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Return in <strong>three</strong> weeks for Doctor and Cycle _______</td>
</tr>
<tr>
<td>☐ Return in <strong>six</strong> weeks for Doctor and Cycle _____ &amp; ______. Book chemo x 2 cycles</td>
</tr>
<tr>
<td>☐ Last Cycle. Return in _________ week(s)</td>
</tr>
</tbody>
</table>

**CBC & Diff, Platelets, Creatinine, Bili, ALT, Alk Phos, Albumin, Sodium, Potassium, Mg, Ca and Blood Pressure Measurement** prior to each cycle

Dipstick Urine or laboratory urinalysis for protein at the beginning of each even numbered cycle. (If results are 2+ or 3+ or greater than or equal to 1 g/L laboratory urinalysis for protein then a **24 hr urine for total protein** must be done within 3 days prior to next cycle.)

☐ INR weekly  ☐ INR prior to each cycle

☐ CEA  ☐ CA 19-9

☐ ECG

☐ Other tests:

☐ Weekly Nursing Assessment for (specify concern): ______________________

☐ Consults:

☐ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**