DOCTOR’S ORDERS

Ht_________cm     Wt_________kg     BSA_________m²

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 72 hours ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/L

Dose modification for:  ☐ Hematology  ☐ Other Toxicity ________________________________

Proceed with treatment based on blood work from _______________

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm ___________________________.
donansetron 8 mg PO prior to treatment
dexamethasone 8 mg or 12 mg (circle one) PO prior to treatment
NO ice chips

☐ Other:

Every 2 weeks ☐ During Radiation(Dual Modality) (3 cycles) or ☐ Post Radiation (3 cycles)

CHEMOTHERAPY: (Note – continued over 2 pages)

☐ Repeat in two weeks

All lines to be primed with D5W

oxaliplatin 85 mg/m² x BSA = _________mg

☐ Dose Modification: _____________mg/m² x BSA = _________mg

IV in 250 to 500 mL D5W over 2 hours*

leucovorin 200 mg/m² x BSA = _________ mg IV in 250 mL D5W over 2 hours*

*oxaliplatin and leucovorin may be infused over same two hour period by using a Y-site connector placed immediately before the injection site

*** SEE PAGE 2 FOR FLUOROURACIL CHEMOTHERAPY ***

DOCTOR’S SIGNATURE:                     SIGNATURE:  

UC:
DATE:

CHEMOTHERAPY: (Continued)

fluorouracil 400 mg/m² x BSA = ______ mg

☐ Dose Modification: __________ mg/m² x BSA = __________ mg

IV push THEN

fluorouracil 1600 mg/m² x BSA = ___________ mg**

☐ Dose Modification: __________ mg/m² x BSA = __________ mg**

IV over 46 hours in D5W to a total volume of 230 mL by continuous infusion at 5 mL/h via Baxter LV5 INFUSOR

** For 3000 to 4600 mg dose, select INFUSOR per dose range below (doses outside dose banding range are prepared as ordered):

<table>
<thead>
<tr>
<th>Dose Banding Range</th>
<th>Dose Band INFUSOR (mg)</th>
<th>Pharmacist Initial and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3000 mg</td>
<td>Pharmacy to mix specific dose</td>
<td></td>
</tr>
<tr>
<td>3000 to 3400 mg</td>
<td>3200 mg</td>
<td></td>
</tr>
<tr>
<td>3401 to 3800 mg</td>
<td>3600 mg</td>
<td></td>
</tr>
<tr>
<td>3801 to 4200 mg</td>
<td>4000 mg</td>
<td></td>
</tr>
<tr>
<td>4201 to 4600 mg</td>
<td>4400 mg</td>
<td></td>
</tr>
</tbody>
</table>

RETURN APPOINTMENT ORDERS

During Radiation (Dual Modality)
Book 3 cycles of chemotherapy every 2 weeks starting Week 1 radiation.
☐ Return in two weeks for Doctor and Cycle ______
☐ Last Cycle with Radiation. Return in 2 weeks for Doctor and Cycle ______.

Post Radiation
☐ Return in twelve weeks for Doctor and Cycle ______
☐ Return in four weeks for Doctor and Cycles ______ & ______. Book chemo x 2 cycles
☐ Last Cycle Post Radiation (3 cycles completed). Return in _______ week(s)

CBC & Diff, Platelets, Creatinine, Bili, ALT, Alk Phos, Sodium, Potassium, Mg, Ca prior to each cycle
☐ INR weekly ☐ INR prior to each cycle ☐ ECG
☐ CEA ☐ CA 19-9 ☐ SCC

Other tests:
☐ Book for PICC assessment / insertion per Centre process
☐ Book for IVAD insertion per Centre process
☐ Weekly Nursing Assessment for (specify concern): __________________________
☐ Radiation consult before Cycle ______ or in ______ weeks.
☐ See general orders sheet for additional requests.

DOCTOR'S SIGNATURE: SIGNATURE:

UC: