DOCTOR’S ORDERS

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

May proceed with doses as written if within 72 hours ANC greater than or equal to $1.5 \times 10^9/L$, Platelets greater than or equal to $75 \times 10^9/L$

Dose modification for:
- [ ] Hematology
- [ ] Other Toxicity ____________________________

Proceed with treatment based on blood work from ____________________________

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm ____________________________.

- Ondansetron 8 mg PO prior to treatment
- Dexamethasone 8 mg or 12 mg (circle one) PO prior to treatment
- Aprepitant 125 mg PO
- Prophylactic atropine 0.3 mg s.c.
- No ice chips
- Other: ____________________________

CHEMOTHERAPY: (Note – continued over 2 pages)

All lines to be primed with D5W

- Oxaliplatin $85 \text{ mg/m}^2 \times \text{BSA} = \underline{\text{__________ mg}}$
  - [ ] Dose Modification: \underline{\text{__________ mg/m}^2 \times \text{BSA}} = \underline{\text{__________ mg}}
  - IV in 250 to 500 mL D5W over 2 hours immediately followed by

- Leucovorin $400 \text{ mg/m}^2 \times \text{BSA} = \underline{\text{__________ mg}}$
  - [ ] Dose Modification: \underline{\text{__________ mg/m}^2 \times \text{BSA}} = \underline{\text{__________ mg}}
  - IV in 250 mL D5W over 2 hours with the addition after 30 minutes of

- Irinotecan $180 \text{ mg/m}^2 \times \text{BSA} = \underline{\text{__________ mg}}$
  - [ ] Dose Modification: \underline{\text{__________ mg/m}^2 \times \text{BSA}} = \underline{\text{__________ mg}}
  - IV in 500 mL DW over 1 hour 30 minutes given through a Y connector placed immediately before the injection site. Immediately followed by

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

DOCTOR’S SIGNATURE: ____________________________

SIGNATURE: ____________________________

UC: ____________________________
DOCTOR’S ORDERS

DATE:

CHEMOTHERAPY: (Continued)

fluorouracil 400 mg/m² x BSA = _________ mg
☐ Dose Modification: _________mg/m² x BSA = _________mg
IV push THEN
fluorouracil 2400 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 5500 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>
<tr>
<td>4601 to 5000 mg</td>
<td>4800 mg</td>
<td></td>
</tr>
<tr>
<td>5001 to 5500 mg</td>
<td>5250 mg</td>
<td></td>
</tr>
<tr>
<td>Greater than 5500 mg</td>
<td>Pharmacy to mix specific dose</td>
<td></td>
</tr>
</tbody>
</table>

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 two weeks for Doctor and Cycle ______

☐ Last Cycle. 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
Other tests:
☐ Book for PICC assessment / insertion per Centre process
☐ Book for IVAD insertion per Centre process
☐ Weekly Nursing Assessment for (specify concern): ______________________
Consults:
☐ See general orders sheet for additional requests.

DOCTOR’S SIGNATURE:  
SIGNATURE:  
UC: