**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 #:**

**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 ________________.

- **dexamethasone 8 mg or 12 mg** (circle one) PO 30 to 60 minutes prior to treatment and select ONE of the following:
  - **aprepitant 125 mg** PO 30 to 60 minutes prior to treatment on Day 1, then **80 mg** PO daily on Day 2 and 3
  - **ondansetron 8 mg** PO 30 to 60 minutes prior to treatment
  - **netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to treatment

- **Prophylactic atropine 0.3 mg SC**
- **NO ice chips**
- Other:

**CHEMOTHERAPY:** (Note – continued over 2 pages)

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 immediately followed by

- **leucovorin 400 mg/m² x BSA = _________ mg**
  - Dose Modification: ___________mg/m² x BSA = _________mg
  - IV in 250 mL D5W over 1 hour 30 minutes*

- **irinotecan 180 mg/m² x BSA = _________ mg**
  - Dose Modification: ___________mg/m² x BSA = _________mg
  - IV in 500 mL D5W over 1 hour 30 minutes*

* irinotecan and leucovorin may be infused at the same time by using a Y connector placed immediately before the injection site. Immediately followed by

*** SEE PAGE 2 FOR FLUOROURACIL CHEMOTHERAPY ***
**DOCTOR’S ORDERS**

**DATE:**

**CHEMOTHERAPY: (Continued)**

fluorouracil 400 mg/m\(^2\) x BSA = _________ mg
- Dose Modification: ___________mg/m\(^2\) x BSA = _________mg

IV push

fluorouracil 2400 mg/m\(^2\) x BSA = _________ mg**
- Dose Modification: ___________mg/m\(^2\) 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 ______
- Return in **four** weeks for Doctor and Cycle ______ and ______
- 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:**