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 of Previous Cycle:

- □ Delay treatment ______ week(s)
- □ CBC & Diff, Platelets day of treatment

May proceed with doses as written if within 48 hours ANC greater than or equal to 1 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L, Creatinine Clearance greater than or equal to 60 mL/minute

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:
- □ Cisplatin 25 mg/m² x BSA = _______ mg
  - □ Dose Modification: ______% = ______ mg/m² x BSA = ______ mg
  - IV in 100 mL NS over 30 minutes weekly x ______ weeks

- □ fluorouracil 1000 mg/m²/day x BSA = ______ mg/day for 2 days (total dose = ______ mg over 48 hours)
  - □ Dose Modification: _____% = ______ mg/m²/day x BSA = _____ mg/day for 2 days (total dose = _____ mg over 48 h)
  - IV in D5W to a total volume of 240 mL by continuous infusion at 5 mL/h via Baxter LV5 infusor weekly (Maximum dose = 5000 mg/48 hours) x _______ weeks

RETURN APPOINTMENT ORDERS

- □ Book weekly chemo x ______ (Max 4)  1 cycle = 1 week
- □ Return in ______ weeks for Doctor and Cycles _______ to _______.
- □ Last Cycle. Return in ________ week(s)

CBC & Diff, Platelets, Creatinine prior to each cycle

If clinically indicated: □ Bilirubin  □ Imaging Studies: ____________________________

- □ INR weekly  □ INR prior to each cycle
- □ Other tests:
  - □ Book for PICC assessment / insertion per Centre process
  - □ Book for IVAD insertion per Centre process
  - □ Weekly Nursing Assessment
  - □ Consults:
  - □ See general orders sheet for additional requests.

DOCTOR’S SIGNATURE: ____________________________

SIGNATURE: ____________________________

UC: ____________________________