**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
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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, creatinine, sodium and potassium day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L, and 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 __________________________.

Select ONE of the following routine antiemetics regimens:

- ☐ ondansetron 8 mg PO 30 to 60 minutes prior to chemotherapy Day 1
- ☐ dexamethasone 8 mg or 12 mg (circle one) PO 30 to 60 minutes prior to chemotherapy Day 1
- ☐ netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to chemotherapy Day 1
- ☐ dexamethasone 8 mg or 12 mg (circle one) PO 30 to 60 minutes prior to chemotherapy Day 1

As needed antiemetics:

- ☐ prochlorperazine 10 mg PO prn prior to chemotherapy
- ☐ metoclopramide 10 mg PO prn prior to chemotherapy
- ☐ Other

**PRE-HYDRATION:** 1000 mL NS over 1 hour pre-CISplatin

**CHEMOTHERAPY:**

CISplatin 80 mg/m² x BSA = ________ mg

- ☐ Dose Modification: ________% = ________ mg/m² x BSA = ________ mg

IV in 500 mL NS with 20 mEq potassium chloride, 1 g magnesium sulphate, 30 g mannitol over 1 hour

capecitabine 1000 mg/m² x ( ________%) = ________mg PO bid with food x 14 days (Total daily dose = 2000 mg/m²/day) (Round dose to nearest 150 mg)

**RETURN APPOINTMENT ORDERS**

- ☐ Return in three weeks for Doctor and Cycle ______
- ☐ Return in _____ weeks for Doctor and Cycle ______
- ☐ Last Cycle. Return in _____ week(s).

CBC & diff, platelets, creatinine, sodium, potassium prior to each cycle

If clinically Indicated:  
- ☐ bilirubin  
- ☐ ALT  
- ☐ Alk Phos  
- ☐ CEA  
- ☐ CA 19-9  
- ☐ SCC

- ☐ INR weekly  
- ☐ INR prior to each cycle

Other tests:

- ☐ Weekly Nursing Assessment for (specify concern): __________________________

Consults:

- ☐ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**