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, 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 10^9/L, Platelets greater than or equal to 100 x 10^9/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 ___________________________.

dexamethasone 8 mg or 12 mg (circle one) PO 30 to 60 minutes prior to chemotherapy on Day 1

and select ONE of the following:

☐ ondansetron 8 mg PO 30 to 60 minutes prior to chemotherapy on Day 1

☐ aprepitant 125 mg PO 30 to 60 minutes prior to chemotherapy on Day 1, then 80 mg PO daily on Day 2 and 3

☐ ondansetron 8 mg PO 30 to 60 minutes prior to chemotherapy on Day 1

☐ netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to chemotherapy on Day 1

☐ 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/m^2 x BSA = _________ mg

☐ Dose Modification: _______% = _______ mg/m^2 x BSA = _________ mg

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

capcitabine 1000 mg/m^2 x BSA x (_______%) = _________ mg PO bid with food x 14 days

(Total daily dose = 2000 mg/m^2/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: