## 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 day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.2 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/L, and Creatinine Clearance greater than or equal to 50 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 prior to chemotherapy
- dexamethasone 8 mg or 12 mg (circle one) prior to chemotherapy
- NO ice chips

**CHEMOTHERAPY:** □ Repeat in three weeks

oxaliplatin line to be primed with D5W; trastuzumab line to be primed with NS

oxaliplatin 130 mg/m² x BSA = ________ mg

- □ Dose Modification: ________mg/m² x BSA = ________mg

  IV in 250 to 500 mL D5W over 2 hours

  □ RN to administer 250 to 1000 mL D5W concurrently with oxaliplatin infusion, titrated to reduce phlebitis discomfort for patient

  □ Cycle 1 Only:

    trastuzumab 8 mg/kg x ________ kg = ________mg IV in 250 mL NS over 1 hour 30 minutes.

    Observe for 1 hour post infusion**

    Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

    | Drug        | Brand (Pharmacist to complete. Please print.) | Pharmacist Initial and Date |
    |-------------|-----------------------------------------------|-----------------------------|
    | trastuzumab |                                               |                             |

  □ Cycle 2

    trastuzumab 6 mg/kg x ________ kg = ________mg IV in 250 mL NS over 1 hour every three weeks x ______Cycle(s)

    Observe for 30 minutes post infusion**

    Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

    | Drug        | Brand (Pharmacist to complete. Please print.) | Pharmacist Initial and Date |
    |-------------|-----------------------------------------------|-----------------------------|
    | trastuzumab |                                               |                             |

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**
DATE: To be given: Cycle #:

CHEMOTHERAPY: ☐ Repeat in three weeks

☐ Cycle 3 and Subsequent:
  trastuzumab 6 mg/kg x ____ kg = ____ mg IV in 250 mL NS over 30 minutes every three weeks x _____Cycle(s)
  Observe for 30 minutes post infusion**.
  **Observation period not required after 3 treatments with no reaction

Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

<table>
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<th>Drug</th>
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acetaminophen 325 to 650 mg PRN for headache and rigors

capcitabine 1000 mg/m² or _____ x BSA x ( _____ %) = _________mg bid with food x 14 days
(Round dose to nearest 150 mg)

RETURN APPOINTMENT ORDERS

☐ Return in three weeks for Doctor and Cycle ________
☐ Return in six weeks for Doctor and Cycle _____ & _______. Book chemo x 2 cycles
☐ Last Cycle. Return in three weeks for GIGAVTR (to continue single agent trastuzumab)

CBC & Diff, Platelets, Creatinine, Bilirubin, ALT, Alk Phos, Sodium, Potassium, Magnesium, Calcium prior to each cycle

☐ INR weekly  ☐ INR prior to each cycle
☐ ECG  ☐ CEA  ☐ CA 19-9
☐ Other tests: ☐ MUGA scan or ☐ Echocardiogram
☐ Radiologic evaluation
☐ Weekly Nursing Assessment for (specify concern): ______________________
☐ Consults:
☐ See general orders sheet for additional requests.

DOCTOR’S SIGNATURE:  SIGNATURE:

UC: