**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 24 hours **ANC greater than or equal to 1.5 x 10⁹/L**, **Platelets greater than 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 treatment

☐ dexamethasone 8 mg or 12 mg (circle one) PO 30 to 60 minutes prior to treatment

☐ netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to treatment

☐ dexamethasone 8 mg or 12 mg (circle one) PO 30 to 60 minutes prior to treatment

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

**CHEMOTHERAPY:**

epirubicin 50 mg/m² x BSA = ________mg

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

IV push

CISplatin 60 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

capcitabine 625 mg/m² x BSA x (______)% = _________mg PO bid with food x 21 days

(Total daily dose = 1250 mg/m²/day)

**RETURN APPOINTMENT ORDERS**

☐ Return in three weeks for Doctor and Cycle _____  
☐ Pre-surgery  
☐ Post-surgery

☐ Return in _____ weeks for Doctor and Cycle _____  
☐ Pre-surgery  
☐ Post-surgery

☐ Last Cycle. Return in ______ week(s).

CBC & diff, platelets, serum creatinine, electrolytes, AST/ALT, alk phos prior to each cycle

☐ INR weekly  
☐ INR prior to each cycle

Other tests:

☐ Weekly Nursing Assessment

Consults:

☐ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**