PROTOCOL CODE: GIPAJGCAP

DOCTOR'S ORDERS

Ht_____cm Wt_____kg BSA_____m^2

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 day 1 as written, if within 48 hours **ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 100 x 10^9/L, Creatinine Clearance greater than 50 mL/min.**

May proceed with doses day 8 and 15 as written, if within 48 hours **ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 100 x 10^9/L,**

Dose modification for: ☐ **Hematology** ☐ **Age/ECOG** ☐ **Other Toxicity** _____

Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

☐ **metoclopramide 10 mg** PO or ☐ **prochlorperazine 10 mg** PO prior to gemcitabine

☐ **Other:**

CHEMOTHERAPY:

gemcitabine 1000 mg/m^2 x BSA = _____mg

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

IV in 250 mL NS over 30 minutes weekly days 1, 8, 15

capecitabine 830 mg/m^2 x BSA x (_____%) = _____mg PO BID x 21 days

(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

DOSE MODIFICATION IF REQUIRED FOR SUBSEQUENT DAYS:

gemcitabine 1000 mg/m^2 x BSA = _____mg

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

IV in 250 mL NS over 30 minutes weekly days _____

capecitabine 830 mg/m^2 x BSA x (_____%) = _____mg PO BID for _____ days

(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

DOCTOR'S ORDERS

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DATE:

RETURN APPOINTMENT ORDERS

☐ Book chemo weekly x 3 weeks ☐ Return in **four** weeks for Doctor and Cycle _____ ☐ Last Cycle. Return in _____ week(s)	
Prior to Day 1: CBC & Diff, Platelets, Creatinine **Prior to Day 8, 15: CBC & Diff, Platelets** If clinically indicated: ☐ **BUN** ☐ **Total Protein** ☐ **ALT** ☐ **Albumin** ☐ **Bilirubin** ☐ **Alk Phos** ☐ **GGT** ☐ **Sodium** ☐ **Potassium** ☐ **INR** weekly ☐ **Other tests:** ☐ **Weekly Nursing Assessment for (specify concern): _____** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**