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, 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 on Days 1, 8, and 15

capecitabine 830 mg/m^2 x BSA x (_____%) = _____mg PO BID on Days 1 to 21

(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 on Days _____

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

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in **four** weeks for Doctor and Cycle _____. Book chemo on Days 1, 8, and 15 ☐ Last Cycle. Return in _____ week(s)	
Prior to Day 1: **CBC & Diff, creatinine, total bilirubin, ALT** Prior to Days 8 and 15: **CBC & Diff** If clinically indicated: ☐ **ECG** ☐ **CEA** ☐ **CA19-9** ☐ **albumin** ☐ **alkaline phosphatase** ☐ **GGT** ☐ **sodium** ☐ **potassium** ☐ **random glucose** ☐ **HbA1c** ☐ **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:**