### DOCTOR’S ORDERS

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<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 day 1 as written, if within 48 hours ANC greater than or equal to 1 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/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 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/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 prior to gemcitabine
- □ prochlorperazine 10 mg PO prior to gemcitabine
- □ Other:

**CHEMOTHERAPY:**

- gemcitabine 1000 mg/m² x BSA = ________mg

  - □ Dose Modification: ________% = ________ mg/m² x BSA = ________ mg
  - IV in 250 mL NS over 30 minutes weekly days 1, 8, 15

- capecitabine 830 mg/m² x BSA x (_______) = _________mg PO bid with food x 21 days
  (Round dose to nearest 150 mg)

**DOSE MODIFICATION IF REQUIRED FOR SUBSEQUENT DAYS:**

- gemcitabine 1000 mg/m² x BSA = ________mg

  - □ Dose Modification: ________% = ________ mg/m² x BSA = ________ mg
  - IV in 250 mL NS over 30 minutes weekly days ___________

- capecitabine 830 mg/m² x BSA x (_______) = _________mg PO bid with food for _______ days
  (Round dose to nearest 150 mg)

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**
## DOCTOR'S ORDERS

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<th>RETURN APPOINTMENT ORDERS</th>
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- [ ] 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
- [ ] AST
- [ ] Albumin
- [ ] Bilirubin
- [ ] Alk Phos
- [ ] GGT
- [ ] Electrolytes

- [ ] INR weekly
- **Other tests:**

- [ ] Weekly Nursing Assessment for (specify concern): _________________
- [ ] Consults:

- [ ] See general orders sheet for additional requests.

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