PROTOCOL CODE: GIPAJGEM

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/Week #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff** day of treatment

May proceed with doses as written if within 48 hours **ANC greater than 1.0 x 10^9/L, platelets greater than 100 x 10^9/L**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity**

Proceed with treatment based on blood work from _____

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

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

☐ **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 x **3** weeks on **Days 1, 8 and 15**

DOSE MODIFICATION IF REQUIRED ON 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 on **Day(s)** _____

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:

☐ **CEA** ☐ **CA19-9** ☐ **ECG**

☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **sodium** ☐ **potassium**

☐ **random glucose** ☐ **HbA1c**

☐ **INR** weekly ☐ **INR** prior to each cycle

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: