**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/Week #:**

**Date of Previous Cycle:**

☐ Delay treatment ______ week(s)

☐ CBC & Diff, Platelets day of treatment

May proceed with doses as written if within 48 hours **ANC greater than** $1 \times 10^9/L$, **Platelets greater than** $100 \times 10^9/L$

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 prior to treatment

☐ Metoclopramide 10 mg PO prior to treatment

☐ Other:

**CHEMOTHERAPY:**  
☐ Weekly x 7 weeks  OR  ☐ Weekly x 3 weeks (select one)

Gemcitabine $1000 \text{ mg/m}^2$ x BSA = _________mg

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

IV in 250 mL NS over 30 minutes

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

Gemcitabine $1000 \text{ mg/m}^2$ x BSA = _________ mg

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

IV in 250 mL NS over 30 minutes on days ____________

**RETURN APPOINTMENT ORDERS**

☐ Book chemo weekly x __________ weeks

☐ Return in **four** or __________ weeks for Doctor and Cycle ______.

☐ Return for Physician only in __________ week(s).

☐ Last Cycle. Return in ________ week(s)

**CBC & Diff, Platelets** prior to each treatment

If clinically indicated:  

☐ Bilirubin  

☐ Creatinine

☐ Tumour Markers:

☐ Imaging Study:

☐ Other tests:

☐ Consults:

☐ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**