BC Cancer Agency
CARE & RESEARCH

PROTOCOL CODE: GUAVD

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** day of treatment
May proceed with doses as written if within 24 hours **ANC greater than or equal to 1.5 x 10^9/L, Platelets greater than or equal to 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 _____.

Ondansetron 8 mg PO prior to treatment

Dexamethasone 8 mg or **12 mg** (circle one) PO prior to treatment

☐ **Other:**

CHEMOTHERAPY:

Doxorubicin 60 mg/m^2 x BSA x (_____%) = _____mg IV push

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____
☐ Last Cycle. Return in _____ week(s).

CBC & Diff, Platelets prior to each treatment day

If clinically indicated: ☐ **Bilirubin** ☐ **GGT** ☐ **AST** ☐ **LDH** ☐ **ALT**
☐ **MUGA** ☐ **Echocardiogram**

☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: