**PROTOCOL CODE: GOENDD**

<table>
<thead>
<tr>
<th><strong>DOCTOR’S ORDERS</strong></th>
<th>Ht________cm Wt________kg BSA________m²</th>
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<tbody>
<tr>
<td><strong>DATE:</strong></td>
<td>To be given:</td>
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Date of Previous Cycle:

- [ ] Delay treatment ______ week(s)
- [ ] CBC & Diff, Platelets day of treatment

May proceed with doses as written if within 96 hours **ANC greater than 1.5 x 10⁹/L, Platelets greater than 100 x 10⁹/L**

Dose modification for:

- [ ] Hematology
- [ ] Other Toxicity ________________

Procede 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 75 mg/m² or 60 mg/m² *(circle one)* x BSA = ____________ mg

- [ ] Dose Modification: _______% = ______ mg/m² x BSA = ____________ mg

IV push.

**RETURN APPOINTMENT ORDERS**

- [ ] Return in three weeks for Cycle ________.
- [ ] Last Cycle. Return in ________ weeks.

CBC & Diff, Platelets, Creatinine, AST, Alk Phos, Bilirubin, GGT, LDH prior to each cycle.

Imaging every other cycle:

- [ ] Chest X-Ray
- [ ] Other, specify

[ ] Other tests:

[ ] Consults:

[ ] See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

SIGNATURE: ________________

UC: ________________