**DOCTOR’S ORDERS**  

<table>
<thead>
<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 day of treatment

May proceed with doses as written if within 96 hours ANC greater than or equal to $1 \times 10^9$/L, Platelets greater than or equal to $100 \times 10^9$/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 ____________________________.

- **dexamethasone□ 8 mg or □ 12 mg (select one) PO prior to treatment.**
- **ondansetron 8 mg PO prior to treatment.**
- □ Other:

  **Have Hypersensitivity Reaction Tray and Protocol Available**

**CHEMOTHERAPY:**

CARBOplatin AUC □ 6 or □ 5 (select one) x (GFR + 25) = _________ mg

- □ Dose Modification: □ % = _________ mg
- IV in 250 mL NS over 30 minutes.

**RETURN APPOINTMENT ORDERS**

- □ Return in **four** weeks for Doctor and Cycle ________
- □ Last Cycle. Return in ________ week(s).

CBC & Diff, Platelets on □ Day 14 □ Day 21.

CBC & Diff, Platelets, Creatinine prior to next cycle.

*If this is Cycle 1 and indicated:* □ CT Scan chest/abdo/pelvis between Cycles 2 & 3

- □ Referral to Gyne Onc Surgeons after CT Scan

Prior to next cycle, if clinically indicated:

- □ Bilirubin □ Alk Phos □ GGT □ ALT □ AST □ LDH
- □ Tot Prot □ Albumin
- □ CA 15-3 □ CA 125 □ CA 19-9

- □ Refer to Hereditary Cancer Program (see accompanying referral form)

- □ Other tests:
- □ Consults:

- □ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

SIGNATURE: UC: