# 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

On Day 1: May proceed with doses as written if within 96 hours **ANC greater than or equal to** 1 x 10⁹/L, **Platelets greater than or equal to** 100 x 10⁹/L

On Days 8 and 15: May proceed with doses as written if within 96 hours **ANC greater than or equal to** 0.5 x 10⁹/L, **Platelets greater than or equal to** 50 x 10⁹/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 30 minutes prior to CARBOplatin.
- 45 minutes prior to PACLitaxel: dexamethasone 10 mg IV in 50 mL NS over 15 minutes
- 30 minutes prior to PACLitaxel: diphenhydrAMINE 25 mg IV and ranitidine 50 mg IV in 50 mL NS over 20 minutes
- [ ] No pre-medication to PACLitaxel required (see protocol for guidelines)

If not receiving IV dexamethasone for PACLitaxel, give: **dexamethasone 8 or 12 mg** (circle one) PO prior to CARBOplatin.

- [ ] Other:

**CHEMOTHERAPY:**

**DAY 1**

- PACLitaxel 70 mg/m² or 60 mg/m² or 80 mg/m² or ____ mg/m² (circle one) x BSA = ________ mg
- [ ] Dose Modification: ____% = ________ mg/m² x BSA = ________ mg
- IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour use non-DEHP tubing with 0.22 micron or smaller in-line filter.

- CARBOplatin AUC 6 or 5 or 4 (circle one) x (GFR + 25) = ________ mg
- [ ] Dose Modification: ____% = ________ mg
- IV in 250 mL NS over 30 minutes.

**DAY 8 and 15**

- PACLitaxel 70 mg/m² or 60 mg/m² or 80 mg/m² or ____ mg/m² (circle one) x BSA = ________ mg
- [ ] Dose Modification: ____% = ________ mg/m² x BSA = ________ mg
- IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing with 0.22 micron or smaller in-line filter).

**if DOSE MODIFICATION REQUIRED ON DAY 8 OR DAY 15:**

- PACLitaxel 60 mg/m² or 50 mg/m² or ____ mg/m² (circle one) x BSA = ________ mg
- IV in 250 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing with 0.22 micron or smaller in-line filter)

- once weekly x ONE or TWO weeks (circle one)

**DOCTOR’S SIGNATURE & DATE MODIFICATION MADE:**

- **DOCTOR’S SIGNATURE:**
- **RN:**
- **UC:**
**RETURN APPOINTMENT ORDERS**

**DATE:**

- Return in **three** weeks for Doctor and Cycle____. Book chemo room weekly x 3.
- Delay next cycle until _____ weeks after surgery.
  - Book Doctor and tentative Cycle____. Obtain O.R. and Pathology Reports in time for RTC.
  - Date of Surgery (if known): _____________________________
- Last Treatment. Return in ______ week(s).

**CBC & Diff, Platelets** prior to each treatment on Days 1, 8, 15.

*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
- Creatinine
- CA 15-3
- CA 125
- CA 19-9
- Magnesium

- For RTC post-surgery: CBC & Diff, Platelets, Creatinine, CA 125.

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

- Other tests:

- Consults:

- See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**RN:**

**UC:**