**DOCTOR’S ORDERS**

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<thead>
<tr>
<th>Ht</th>
<th>cm</th>
<th>Wt</th>
<th>kg</th>
<th>BSA</th>
<th>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 1.0 x 10⁹/L, Platelets greater than or equal to 100 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 ___________________________.

If *prior* infusion reaction:

- **doxymethasone 20 mg IV in 50 mL NS over 15 minutes**
- **diphenhydramine 50 mg IV and ranitidine 50 mg IV in 50 mL NS over 20 minutes**
- **ondansetron 8 mg PO 30 minutes prior to CARBOplatin.**
- **dexamethasone 8 mg PO 30 minutes prior to CARBOplatin.**

- Other:

  **“Have Hypersensitivity Reaction Medications and Protocol Available”**

**CHEMOTHERAPY:**

All lines to be primed with D5W (CARBOplatin is compatible with both NS and D5W)

- **DOXOrubicin pegylated liposomal (CAELYX):**
  - 30 mg/m² or 25 mg/m² (select one) x BSA = ______ mg
  - Dose Modification: ______ mg/m² x BSA = ______ mg
  - IV in 250 mL D5W over 1 h*

- **CARBOplatin AUC 5 or 4 (select one) x (GFR + 25) = ______ mg**
  - Dose Modification: ______% = ______ mg
  - IV in 250mL NS over 30 minutes.

**RETURN APPOINTMENT ORDERS**

- Return in four weeks for Doctor and Cycle
- Last Treatment. Return in ______ week(s).

**Cycle 1:** CBC & Diff, Platelets, Creatinine prior to Day 1, and CBC & Diff, Platelets on Days 14, and 21.

If this is Cycle 1 and indicated:

- CT Scan chest/abdo/pelvis between Cycles 2 & 3
- Referral to Gyne Onc Surgeons after CT Scan

Subsequent cycles: CBC & Diff, Platelets, Creatinine prior to Day 1; if indicated, also on Day 14 and/or Day 21.

Prior to next cycle, if clinically indicated:

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

- Refer to Hereditary Cancer Program (see accompanying referral form)
- Consults:
  - See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

UC:

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BC Cancer Provincial Preprinted Order GOOVFPLDC

Created: 1 Sep 2018    Revised: 9 Nov 2020