**DOCTOR’S ORDERS**  

<table>
<thead>
<tr>
<th>Unit</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ht</td>
<td>______cm</td>
</tr>
<tr>
<td>Wt</td>
<td>______kg</td>
</tr>
<tr>
<td>BSA</td>
<td>______m²</td>
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</tbody>
</table>

**REMININDER:** 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 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:**  
- Prochlorperazine 10 mg PO prior to treatment  
- Metoclopramide 10 mg PO prior to treatment  
- Other:  

**CHEMOTHERAPY:**  
Gemcitabine 800 mg/m² x BSA = ________ mg  

- Dose Modification: ________mg/m² x BSA = ________mg  

IV in 250 mL NS over 30 minutes on Day 1, 8 and 15.

**DOSE MODIFICATION** (If required for Day 8 and/or 15)  
Day 8 and 15 OR Day 15 (circle one)  

Gemcitabine 800 mg/m² x BSA = ________ mg  

- Dose Modification: ________% = ___________mg/m² x BSA = _________mg  

IV in 250 mL NS over 30 minutes.

**RETURN APPOINTMENT ORDERS**  

- Return in **four** weeks for Doctor and Cycle _____.
- Book chemo Day 1, 8 and 15.  
- Last Cycle. Return in ____________weeks.

- Cycle 1: CBC & Diff, platelets prior to Day 1, and on Days 8, and 15.  
- Subsequent cycles: CBC & Diff, platelets prior to Day 1; if indicated, also on Day 8 and/or Day 15.  
- Other tests:  
- Consults:  
- See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**  

**SIGNATURE:**  

**UC:**