**DOCTOR’S ORDERS**

- **Ht**: _____________ cm
- **Wt**: _____________ kg
- **BSA**: _____________ m²

**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 24 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:**

- prochlorperazine: 10 mg PO prior to treatment
- metoclopramide: 10 mg PO prior to treatment
- Other: __________________

**CHEMOTHERAPY:**

- gemcitabine: $800 \text{ mg/m}^2 \times \text{BSA} = ________ \text{mg}$
  - Dose Modification: $_______ \text{mg/m}^2 \times \text{BSA} = ________ \text{mg}$
  - 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 1: ___________ OR Day 15: (select one)

- gemcitabine: $800 \text{ mg/m}^2 \times \text{BSA} = ________ \text{mg}$
  - Dose Modification: ________% = $_______ \text{mg/m}^2 \times \text{BSA} = ________ \text{mg}$
  - 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.

If clinically indicated:  
- CA 125  
- CA 15-3  
- CA 19-9  
- CEA  

**Other tests:**

- Consults:
- See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

UC: