PROTOCOL CODE: GOOVVIN

DOCTOR’S ORDERS

Ht____________cm   Wt___________kg   BSA____________m$^2$

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 Day 1 doses as written if within 24 hours ANC greater than or equal to 1 x 10$^9$/L, Platelets greater than or equal to 100 x 10$^9$/L

Dose modification for:  ☐ Hematology  ☐ Other Toxicity ____________________________

Proceed with treatment based on blood work from ____________________________

PREMEDICATIONS:

☐ hydrocortisone 100 mg IV PRN

☐ Other:

CHEMOTHERAPY:

vinorelbine 25 mg/m$^2$ x BSA = ______________ mg

☐ Dose Modification: _______% = _______ mg/m$^2$/day x BSA = ______________ mg

IV in 50 mL NS over 6 minutes on Day 1 and 8.

Flush vein with 75 to 125 mL NS following infusion of Vinorelbine.

RETURN APPOINTMENT ORDERS

☐ Return in three weeks for Doctor and Cycle #_______. Book chemo Day 1 and 8.

☐ Last Cycle. Return in ______ week(s).

CBC & Diff, Platelets prior to Day 1, each cycle. No labs required prior to Day 8 treatment.

If clinically indicated:  ☐ CEA  ☐ CA 15-3  ☐ CA-125  ☐ CA 19-9  prior to treatment

☐ Other tests:

☐ Consults:

☐ See general orders sheet for additional requests.

DOCTOR’S SIGNATURE:  SIGNATURE:

UC: