**DOCTOR'S ORDERS**

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
</tr>
</thead>
</table>

**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form.

**DATE:**

<table>
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<tr>
<th>To be given</th>
<th>Cycle #</th>
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**Date of Previous Cycle:**

- [ ] Delay treatment ______ week(s)
- [ ] CBC & Diff, Platelets, Creatinine 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** 100 x 10⁹/L, **Creatinine Clearance greater than or equal to** 60 mL/min.

**Dose modification for:**

- [ ] Hematology
- [ ] Other Toxicity: _____________________________

Proceed with treatment based on blood work from _________________________.

**PREMEDICATIONS:**

- Patient to take own supply. RN/Pharmacist to confirm ___________________________.
- **ondanestron 8 mg** PO prior to treatment
- **dexamethasone 8 mg** or **12 mg** (circle one) prior to treatment
- **prochlorperazine 10 mg** PO prior to treatment
- [ ] Other:

**CHEMOTHERAPY:**

- **CISplatin 25 mg/m²/day** x BSA = _______ mg

- [ ] Dose Modification: _______% = _______ mg/m² x BSA = _______ mg

  IV in NS 100 mL over 30 minutes on **Days 1 and 8**

**DOSE MODIFICATION REQUIRED ON DAY 8:**

- **CISplatin 25 mg/m²/day** x BSA x ( _____ %) = _______ mg IV in NS 100 mL over 30 minutes on **Day 8**

**RETURN APPOINTMENT ORDERS**

- [ ] Last Cycle. Return in _______ week(s).

**CBC & Diff, Platelets, Creatinine** prior to Day 1 and 8

- [ ] Other tests:
- [ ] Consults:
- [ ] See general orders sheet for additional requests.

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**