**DOCTOR’S ORDERS**

<table>
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<tr>
<th>Ht(cm)</th>
<th>Wt(kg)</th>
<th>BSA(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, Creatinine, ALT, Bilirubin, Alkaline Phosphatase day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L, Creatinine less than or equal to 120 micromol/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 ___________________________.
- ondansetron 8 mg PO prior to treatment
- dexamethasone 8 mg PO prior to treatment
- Other:

**CHEMOTHERAPY:**

**Concurrent With Radiation Therapy**

- CARBOplatin 70 mg/m² x BSA = _________ mg
- Dose Modification: ______% = ______ mg/m² x BSA = _________ mg
- IV in NS 250 mL over 30 minutes Days 1 to 4
- fluorouracil 600 mg/m²/day x BSA = _________ mg/day for 4 days (total dose = _________ mg over 96 h)
- Dose Modification: ______ mg/m²/day x BSA = _________ mg/day for 4 days (total dose = _________ mg over 96 h)
- IV in D5W to a total volume of 480 mL by continuous infusion at 5 mL/h via TWO Baxter LV5 infusors (Total dose should be divided equally – each 240 mL over 48 hours)

**RETURN APPOINTMENT ORDERS**

- Return in three weeks for Doctor and Cycle _________
- Return in 2 days for second fluorouracil infusor
- Last Cycle. Return in _______ week(s).

**CBC & Diff, Platelets, Creatinine, Bilirubin, ALT, Alkaline Phosphatase** prior to each cycle

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

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**