PROTOCOL CODE: HNLACART3

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)
☐ Day of treatment: **CBC & Diff**

May proceed with doses as written, if within 96 hours **ANC greater than or equal to 1.0 x 10^9/L** and **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: Patient to take own supply. RN/Pharmacist to confirm _____.

dexamethasone ☐ **8 mg** or ☐ **12 mg** (select one) 30 to 60 minutes prior to treatment

AND select **ONE** of the following:	☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to treatment
	☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to treatment, and **ondansetron 8 mg** PO 30 to 60 minutes prior to treatment
	☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to treatment

If additional antiemetic required:

☐ **OLANZapine** ☐ **2.5 mg** or ☐ **5 mg** or ☐ **10 mg** (select one) PO 30 to 60 minutes prior to treatment

☐ **Other:**

**** Have Hypersensitivity Reaction Tray and Protocol Available****

TREATMENT:

CARBOplatin AUC 5 x (GFR + 25) =_____ mg

☐ Dose Modification: _____% = _____ mg

IV in 100 to 250 mL NS over 30 minutes

RETURN APPOINTMENT ORDERS

☐ Return in 3 weeks for Doctor and Cycle _____.
☐ Last Cycle. Return in _____ week(s).

CBC & diff, creatinine, sodium, potassium, magnesium, calcium, and phosphate, albumin prior to each treatment

☐ If clinically indicated: ☐ ALT ☐ total bilirubin

☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: