**PROTOCOL CODE: HNNAVUFA**

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<tr>
<th>DOCTOR’S ORDERS</th>
<th>Ht</th>
<th>cm</th>
<th>Wt</th>
<th>kg</th>
<th>BSA</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 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

Dose modification for:  ☐ Hematology  ☐ Other Toxicity ____________________________

Proceed with treatment based on blood work from ____________________________

**PREMEDICATIONS:** Patient to take own supply. RN/Pharmacist to confirm ____________________________

**CHEMOTHERAPY:**

leucovorin 20 mg/m² x BSA = _________ mg IV push prior to fluorouracil weekly x _______ weeks.

fluorouracil 500 mg/m² x BSA x ( _____ %) = _________ mg IV push weekly x ________ weeks.

**RETURN APPOINTMENT ORDERS**

☐ Return in **two** or **four** (circle one) weeks for Doctor and Cycle ________

Book chemo x __________ weeks.

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

**CBC & Diff, Platelets** every two weeks.

IF clinically indicated:  ☐ Bilirubin, **ALT**, alkaline phosphatase

☐ Other tests:

☐ Consults:

☐ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:** ____________________________

**SIGNATURE:** ____________________________

UC: ____________________________