**PROTOCOL CODE: HNNAV Gem**

### DOCTOR’S ORDERS

<table>
<thead>
<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 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**

Dose modification for:

- [ ] Hematology
- [ ] Other Toxicity

Proceed with treatment based on blood work from ____________________________

### PREMEDICATIONS:

- Patient to take own supply. RN/Pharmacist to confirm _____________________________.

- [ ] Prochlorperazine 10 mg PO prior to treatment

- [ ] Metoclopramide 10 mg PO prior to treatment

- [ ] Other:

### CHEMOTHERAPY:

- **Gemcitabine 1250 mg/m² x BSA = ____ mg**
  - Dose Modification: ____% = ________mg/m² x BSA = _________mg
  - IV in 250 mL NS over 30 minutes on **Day 1 and Day 8**

### DOSE MODIFICATION FOR DAY 8:

- **Gemcitabine 1250 mg/m² x BSA = ____ mg**
  - Dose Modification: ____% = ________mg/m² x BSA = _________mg
  - IV in 250 mL NS over 30 minutes

### RETURN APPOINTMENT ORDERS

- [ ] Return in **three** weeks for Doctor and Cycle _____. Book chemo Day 1 and Day 8

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

**CBC & Diff, Platelets** prior to each treatment

If clinically indicated: [ ] Bilirubin [ ] Creatinine

- [ ] Other tests:

- [ ] Consults:

- [ ] See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**