**PROTOCOL CODE: HNNAVP**

**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 #:

**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 $1 \times 10^9$/L, Platelets greater than $100 \times 10^9$/L, Creatinine Clearance greater than or equal to 60 mL/min.

**Dose modification for:**
- [ ] Hematology
- [ ] Other Toxicity: ___________________________

**PREMEDICATIONS:**

- Ondansetron 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: _____________________________

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

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