## DOCTOR'S ORDERS

| Ht _______ cm | Wt _______ kg | BSA _______ m² |

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 day of treatment

May proceed with doses as written if within 24 hours **ANC greater than or equal to 1.0** x 10⁹/L, **Platelets greater than or equal to** 75 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 pre-chemotherapy PRN
- □ metoclopramide 10 mg PO pre-chemotherapy PRN

## CHEMOTHERAPY:

All lines to be primed with D5W.

**DOXOrubicin pegylated liposomal (CAELYX)** 20 mg/m² x BSA = ______ mg

- □ Dose Modification: (_______ %) = _______ mg/m² x BSA = _______ mg

IV in 250 mL D5W over 1 h*

*In Cycle 1, infuse over at least 1 h (maximum 1mg/min). For subsequent doses and no prior reaction, infuse over 1 h.

## RETURN APPOINTMENT ORDERS

- □ Return in _______ weeks for Doctor and Cycle _______.
- □ Last Cycle. Return in _______ week(s).

CBC and Diff, Platelets prior to each cycle

If clinically indicated:

- □ Tot. Prot
- □ Albumin
- □ Bilirubin
- □ GGT
- □ Alk Phos.
- □ LDH
- □ ALT
- □ BUN
- □ Creatinine

- □ Other tests: (ie: ECG, Echocardiogram, MUGA Scan) _____________________________

- □ Consults:

- □ See general orders sheet for additional requests.

## DOCTOR'S SIGNATURE:

| SIGNATURE: |

UC: