PROTOCOL CODE: LKAMLCYT

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)

☐ **CBC & Diff** day of treatment

Cycle 1 ONLY: May proceed with doses as written. No specific blood count requirements

Cycles 2-4:

May proceed with doses as written if within 48 hours **ANC greater than or equal to 1.5 x 10^9/L, 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 _____.

☐ **Other:**

TREATMENT:

cytarabine 20 mg subcutaneous bid for 10 consecutive days starting _____.

Prescriptions need to be provided for pharmacy at least 24 hours before patient pick-up

☐ **Special Instructions:**

RETURN APPOINTMENT ORDERS

☐ Return in ☐ four weeks or ☐ six weeks (select one) for Doctor and Cycle _____.

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

CBC & Diff prior to each cycle

If clinically indicated: ☐ **total bilirubin** ☐ **GGT** ☐ **alkaline phosphatase**
☐ **LDH** ☐ **ALT** ☐ **serum creatinine and uric acid**
☐ **HBV viral load**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: