## DOCTOR’S ORDERS

<table>
<thead>
<tr>
<th>Ht</th>
<th>cm</th>
<th>Wt</th>
<th>kg</th>
<th>BSA</th>
<th>m²</th>
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**REMINDER:** Please ensure drug allergies are documented on the Allergy & Alert Form

**DATE:** To be given: Cycle #: 

Date of Previous Cycle: 

- [ ] Delay treatment ______ week(s) 
- [ ] CBC & Diff and platelets, bilirubin, creatinine day 1 of treatment 

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:** Week 3 to 8 ONLY: 

- [ ] cycloSPORINE 3 mg/kg x Wt = ___________ mg PO BID (round to the nearest 25 mg) 
  Mitte: ____________ capsules

- [ ] week 3 and 4: dexamethasone 5 mg/m² x BSA = ___________ mg PO daily (round to the nearest 2 mg) 
  Mitte: ____________ tablets OR

- [ ] week 5 and 6: dexamethasone 2.5 mg/m² x BSA = ___________ mg PO daily (round to the nearest 0.5 mg) 
  Mitte: ____________ tablets OR

- [ ] week 7 and 8: dexamethasone 1.25 mg/m² x BSA = ___________ mg PO daily (round to the nearest 0.5 mg) 
  Mitte: ____________ tablets

- [ ] etoposide 150 mg/m² x BSA = ___________ mg 
  Dose Modification: _______% = ___________ mg/m² x BSA = ___________ mg 
  IV in 500 to 1000 mL (non-DEHP bag) NS over 45 to 90 minutes on Days 15, 22, 29, 36, 43, 50 (Use non-DEHP tubing with 0.22 micron or smaller in-line filter)

**EMERGENCY DRUGS FOR MANAGEMENT OF ETOPOSIDE TOXICITY:**

- hydrocortisone 100 mg IV prn / diphenhydrAMINE 50 mg IV prn

See page 2

**DOCTOR’S SIGNATURE**

**SIGNATURE**

UC:
<table>
<thead>
<tr>
<th>DOCTOR’S ORDERS (Page 2 of 3)</th>
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<tr>
<td>DATE:</td>
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<tr>
<th>RETURN APPOINTMENT ORDERS</th>
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<tbody>
<tr>
<td>☐ Return in <strong>two</strong> weeks for Doctor and weeks ________. Book chemo on Day 1.</td>
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<tr>
<td>☐ Last Cycle. Return in ______ week(s).</td>
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<tr>
<th>CBC &amp; Diff, platelets, creatinine, bilirubin weekly</th>
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<tr>
<td>cycloSPORINE trough levels weekly once cycloSPORINE initiated</td>
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<tr>
<td>☐ If clinically indicated: ☐ AST ☐ ALT ☐ LDH ☐ ferritin ☐ CMV DNA levels</td>
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<tr>
<td>☐ EBV DNA levels</td>
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<tr>
<td>☐ lumbar puncture with CSF analysis (cell count and differential, protein and glucose)</td>
</tr>
<tr>
<td>☐ Other tests:</td>
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<td>☐ Consults:</td>
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<td>☐ See general orders sheet for additional requests.</td>
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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 and Platelets prior to day 1, 8 and 15 of treatment
  - May proceed with doses as written if within 24 hours **ANC greater than or equal to 0.5 x 10⁹/L**, **Platelets greater than or equal to 40 x 10⁹/L**

**Dose modification for:**

- ☐ Hematology
- ☐ Other Toxicity

**Proceed with treatment based on blood work from**

**INTRATHECAL (IT) CHEMOTHERAPY:**

- methotrexate ________ mg (standard dose 12 mg) and **hydrocortisone ________ mg** (standard dose 50 mg) qs to 6 mL with preservative-free NS intrathecally on week ____________.

**RETURN APPOINTMENT ORDERS**

- ☐ Return in 1 week for Doctor and week ________.
- ☐ Last Cycle. Return in ________ week(s).

**Other tests:**

- ☐ Consults:
- ☐ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**

**MEDICATION VERIFICATION CHECKS**

Full Signatures Required

- **Date (dd/mm/yy)**

- methotrexate ________ mg and
  - hydrocortisone ________ mg IT

- (RN)

- (MD)