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, Platelets day of treatment

May proceed with doses as written if within 96 hours ANC greater than 1.2 \times 10^9/L, Platelets greater than 80 \times 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 ____________________________.
ondanetron 8 mg PO prior to treatment.
dexamethasone 8 mg or 12 mg (circle one) PO prior to treatment.
☐ Other:

CHEMOTHERAPY:

IV cyclophosphamide _________ mg/m^2 = _________ mg
☐ Dose Modification: ________% = _________ mg/m^2 x BSA = _________ mg
IV in 100 to 250 mL NS over 20 minutes to 1 hour.

OR

Oral cyclophosphamide _________ mg/m^2/day = _________ mg PO daily x 5 days. (Round dose to nearest 25 mg)

OPTIONAL:
prednisone 45 mg/m^2/day = _________ mg PO daily in the AM with food x 5 days. (Round dose to nearest 25 mg)

RETURN APPOINTMENT ORDERS

☐ Return in three weeks for Doctor and Cycle __________
☐ Last Cycle. Return in _________ week(s).

CBC & Diff, Platelets prior to each cycle

☐ Other tests:

☐ Consults:

☐ See general orders sheet for additional requests.

DOCTOR’S SIGNATURE:                                             SIGNATURE:  
UC:  

BC Cancer Provincial Preprinted Order LYCYCLO
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