**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:**

| 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 or equal to 1.2 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L, and Creatinine Clearance greater than 70 mL/min

Dose modification for: □ Hematology  □ Other Toxicity ____________________________

Proceed with treatment based on blood work from ________________________________

**CHEMOTHERAPY:**

**Standard Dose:**

**Oral Fludarabine 40 mg/m²/day** x BSA = _______ mg PO daily for 5 consecutive days.

Round dose to nearest 10 mg. Do not break, chew or crush tablets.

**OR**

**Dose Modification Required:**

**Oral Fludarabine 32 mg/m²/day** x BSA = _______ mg PO daily for 3 consecutive days.

Round dose to nearest 10 mg. Do not break, chew or crush tablets.

**OR**

**Standard Dose:**

**IV Fludarabine 25 mg/m²/day** x BSA = __________ mg

IV in 50 to 100 mL NS over 20 to 30 minutes daily for 5 days.

**OR**

**Dose Modification Required:**

**IV Fludarabine 20 mg/m²/day** x BSA = __________ mg

IV in 50 to 100 mL NS over 20 to 30 minutes daily for 3 days.

**RETURN APPOINTMENT ORDERS**

**For Oral Use:**

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

**For IV use:**

- □ Return in four weeks for Doctor and Cycle _______. Book chemo x 5 or 3 days (circle one). (Match to dose duration above)
- □ Last Cycle. Return in _______ week(s).

**CBC & Diff, platelets, creatinine** prior to each cycle.

- □ Other tests:
- □ Consults:
- □ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

UC: