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 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 IT (standard dose 12 mg) on Days 1, 8 and 15.
Cytarabine ________mg IT (standard dose 50 mg) on Days 4, 11 and 18.

RETURN APPOINTMENT ORDERS

☐ Return in _______ weeks for Doctor and Cycle ________.
Book chemo Days 1, 4, 8, 11, 15 and 18 q 3 weeks.
☐ Last Cycle. Return in _______ week(s).

CBC & Diff, Platelets prior to Days 1, 8 and 15.
☐ Other tests:
☐ Consults:
☐ See general orders sheet for additional requests.

DOCTOR’S SIGNATURE:  SIGNATURE:  UC:

MEDICATION VERIFICATION CHECKS
Full Signatures Required

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<tr>
<th>Medication/Route</th>
<th>Day 1</th>
<th>Day 4</th>
<th>Day 8</th>
<th>Day 11</th>
<th>Day 15</th>
<th>Day 18</th>
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<tr>
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