**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
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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, Platelets day of treatment

May proceed with doses as written if within 96 hours ANC **greater than or equal to** \(1.5 \times 10^9/L\), Platelets **greater than or equal to** \(100 \times 10^9/L\).

Dose modification for:

- [ ] Hematology
- [ ] Other Toxicity ________________________________

Proceed with treatment based on blood work from ________________________________

**PREMEDICATIONS:**

Patient to take own supply. RN/Pharmacist to confirm ________________________________.

- **Ondansetron 8 mg** PO prior to treatment
- **Dexamethasone 8 mg or 12 mg** (circle one) PO prior to treatment

- [ ] Other:

**CHEMOTHERAPY:**

**DOX**Oribcin \(75 \text{ mg/m}^2 \times \text{BSA} = \) ________ mg

- [ ] Dose Modification: ________% = ________ mg/m² \(\times\) BSA = ________ mg

IV push.

**RETURN APPOINTMENT ORDERS**

- [ ] Return in **three** weeks for Cycle _______.
- [ ] Last Cycle. Return in _________ weeks.

CBC & Diff, Platelets prior to each treatment.

If Clinically Indicated:

- [ ] Bilirubin

- [ ] measure of LVEF (specify): ________________________________

- [ ] ECG

- [ ] Other tests:

- [ ] Consults:

- [ ] See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**