PROTOCOL CODE: SAAJADIC

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 or equal to 1.5 x 10^9/L, Platelets greater than or equal to 100 x 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 _____.

dexamethasone ☐ **8 mg** or ☐ **12 mg** (select one) PO 30 to 60 minutes prior to treatment

and **select** ONE of the following:

☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to treatment **ondansetron 8 mg** PO 30 to 60 minutes prior to treatment
☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to treatment

☐ Other:

CHEMOTHERAPY:

DOXOrubicin ☐ **60 mg/m^2 or** ☐ **_____ mg/m^2** (select one) x BSA= _____ mg

☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg

IV push.

dacarbazine 850 mg/m^2 x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg

IV in 500 to 1000 mL NS over 1 to 2 hours

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Cycle _____.

☐ Last Cycle. Return in _____ weeks.

CBC & Diff, Platelets, ALT, Alk Phos, Bilirubin, GGT, LDH prior to each treatment.

☐ **CXR**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: