

**PROTOCOL CODE: BRAJDC**

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<b>DOCTOR'S ORDERS</b>		Ht _____ cm    Wt _____ kg    BSA _____ m <sup>2</sup>
<b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>		
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle #:</b>
Date of Previous Cycle: _____		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff</b> day of treatment May proceed with doses as written if within 96 hours <b>ANC greater than or equal to 1.0 x 10<sup>9</sup>/L, platelets greater than or equal to 100 x 10<sup>9</sup>/L</b> Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____ Proceed with treatment based on blood work from _____		
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____. <b>ondansetron 8 mg PO</b> prior to treatment <b>dexamethasone 8 mg PO bid</b> for 3 days starting one day prior to DOCEtaxel; patient must receive 3 doses prior to treatment <b>Optional: Frozen gloves</b> starting 15 minutes before DOCEtaxel infusion until 15 minutes after end of DOCEtaxel infusion; gloves should be changed after 45 minutes of wearing. <input type="checkbox"/> <b>Other:</b> _____		
<b>** Have Hypersensitivity Reaction Tray and Protocol Available**</b>		
<b>TREATMENT:</b>  <b>cyclophosphamide 600 mg/m<sup>2</sup> x BSA = _____ mg</b> <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 100 to 250 mL NS over 20 minutes to 1 hour  <b>DOCEtaxel 75 mg/m<sup>2</sup> x BSA = _____ mg</b> <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 250 to 500 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing)		
<b>RETURN APPOINTMENT ORDERS</b>		
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____ Post Cycle 1 only: Book filgrastim (G-CSF) SC teaching and first dose on Day _____ <input type="checkbox"/> Last Cycle. Return in _____ week(s).		
<b>CBC &amp; Diff</b> prior to each cycle If clinically indicated: <input type="checkbox"/> <b>total bilirubin</b> <input type="checkbox"/> <b>creatinine</b> <input type="checkbox"/> <b>GGT</b> <input type="checkbox"/> <b>LDH</b> <input type="checkbox"/> <b>ALT</b> <input type="checkbox"/> <b>alkaline phosphatase</b> <input type="checkbox"/> <b>Other tests:</b> <input type="checkbox"/> <b>Consults:</b> <input type="checkbox"/> <b>See general orders sheet for additional requests.</b>		
<b>DOCTOR'S SIGNATURE:</b>		<b>SIGNATURE:</b>
		<b>UC:</b>