

<b>DOCTOR'S ORDERS</b>		Ht _____ cm	Wt _____ kg	BSA _____ m <sup>2</sup>
<b>REMINDER:</b> Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form				
<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>dexamethasone</b> <input type="checkbox"/> <b>8 mg</b> or <input type="checkbox"/> <b>12 mg</b> (select one) PO 30 to 60 minutes prior to FEC treatment and <b>select ONE</b> of the following:				
<input type="checkbox"/>	<b>ondansetron 8 mg</b> PO 30 to 60 minutes prior to FEC treatment			
<input type="checkbox"/>	<b>aprepitant 125 mg</b> PO 30 to 60 minutes prior to FEC treatment			
<input type="checkbox"/>	<b>ondansetron 8 mg</b> PO 30 to 60 minutes prior to FEC treatment			
<input type="checkbox"/>	<b>netupitant-palonosetron 300 mg-0.5 mg</b> PO 30 to 60 minutes prior to FEC treatment			
<b>For DOCEtaxel cycles:</b> <b>dexamethasone 8 mg</b> PO bid 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>hydrocortisone 100 mg</b> IV PRN <input type="checkbox"/> <b>Other:</b> _____				
<b>** Have Hypersensitivity Reaction Tray and Protocol Available **</b>				
<b>TREATMENT:</b>				
<b>epirubicin 100 mg/m<sup>2</sup></b> x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV push <b>fluorouracil 500 mg/m<sup>2</sup></b> x BSA x = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV push <b>cyclophosphamide 500 mg/m<sup>2</sup></b> x BSA = _____ mg <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>OR</b> <b>DOCEtaxel 100 mg/m<sup>2</sup></b> x BSA = _____ mg <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 _____ <b>Post Cycle 1 only: Book filgrastim (G-CSF) SC teaching and first dose on Day _____</b> <input type="checkbox"/> Last Cycle. Return in _____ week(s).				
<b>CBC &amp; Diff</b> prior to each cycle Prior to <b>Cycle 4:</b> <b>total bilirubin, alkaline phosphatase, ALT</b> 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>urea</b> <input type="checkbox"/> <b>MUGA scan</b> <input type="checkbox"/> <b>Echocardiogram</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>