

PROTOCOL CODE: GOOVGAG

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:				
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff day of treatment May proceed with doses as written if within 24 hours ANC greater than or equal to 1.0 x 10⁹/L, platelets greater than or equal to 100 x 10⁹/L Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____				
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.				
dexamethasone 8 mg PO 30 to 60 minutes prior to CARBOplatin				
AND select ONE of the following:	<input type="checkbox"/>	ondansetron 8 mg PO 30 to 60 minutes prior to CARBOplatin		
	<input type="checkbox"/>	aprepitant 125 mg PO 30 to 60 minutes prior to CARBOplatin, and ondansetron 8 mg PO 30 to 60 minutes prior to CARBOplatin		
	<input type="checkbox"/>	netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to CARBOplatin		
If additional antiemetic required:				
<input type="checkbox"/> OLANzapine <input type="checkbox"/> 2.5 mg or <input type="checkbox"/> 5 mg or <input type="checkbox"/> 10 mg (select one) PO 30 to 60 minutes prior to CARBOplatin <input type="checkbox"/> Other:				
Have Hypersensitivity Reaction Tray and Protocol Available				
TREATMENT:				
DAY 1				
gemcitabine <input type="checkbox"/> 800 mg/m ² OR <input type="checkbox"/> _____ mg/m ² (select one) x BSA = _____ mg				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg				
IV in 250 mL NS over 30 minutes. (Maximum Dose = 2000 mg)				
CARBOplatin AUC <input type="checkbox"/> 5 OR <input type="checkbox"/> 6 OR <input type="checkbox"/> 4 (select one) X (GFR+25) = _____ mg				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg				
IV in 100 to 250 mL NS over 30 minutes, after gemcitabine.				
DAY 8				
gemcitabine <input type="checkbox"/> 800 mg/m ² OR <input type="checkbox"/> _____ mg/m ² (select one) x BSA = _____ mg				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg				
IV in 250 mL NS over 30 minutes. (Maximum Dose = 2000 mg)				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in three weeks for Doctor and Cycle # _____. Book chemo Day 1 and 8				
<input type="checkbox"/> Last Cycle. Return in _____ week(s).				
CBC & Diff, creatinine prior to Day 1 each cycle CBC & Diff , prior to Day 8 each cycle If clinically indicated: <input type="checkbox"/> sodium <input type="checkbox"/> potassium <input type="checkbox"/> magnesium <input type="checkbox"/> calcium <input type="checkbox"/> ALT <input type="checkbox"/> total bilirubin <input type="checkbox"/> CA 125 <input type="checkbox"/> CA 15-3 <input type="checkbox"/> CA 19-9 <input type="checkbox"/> CEA <input type="checkbox"/> SCC <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:				SIGNATURE:
				UC: