



Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at [www.bccancer.bc.ca/terms-of-use](http://www.bccancer.bc.ca/terms-of-use) and according to acceptable standards of care.

**PROTOCOL CODE: GIPGEM**

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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/Week #:</b>
Date of Previous Cycle: _____		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff, Platelets</b> day of treatment May proceed with doses as written if within 48 hours <b>ANC greater than 1.0 x 10<sup>9</sup>/L, Platelets greater than 100 x 10<sup>9</sup>/L</b> Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> <b>Proceed with treatment based on blood work from</b> _____		
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____. <input type="checkbox"/> <b>prochlorperazine 10 mg PO</b> or <input type="checkbox"/> <b>metoclopramide 10 mg PO</b> prior to treatment <input type="checkbox"/> <b>Other:</b> _____		
<b>CHEMOTHERAPY:</b> <input type="checkbox"/> <b>Weekly x 7 weeks</b> OR <input type="checkbox"/> <b>Weekly x 3 weeks</b> (select one) <b>gemcitabine 1000 mg/m<sup>2</sup> x BSA =</b> _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 250 mL NS over 30 minutes		
<b>DOSE MODIFICATION IF REQUIRED ON SUBSEQUENT DAYS:</b> <b>gemcitabine 1000 mg/m<sup>2</sup> x BSA =</b> _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 250 mL NS over 30 minutes on days _____		
<b>RETURN APPOINTMENT ORDERS</b>		
<input type="checkbox"/> Book chemo weekly x _____ weeks <input type="checkbox"/> Return in <b>four</b> or _____ weeks for Doctor and Cycle _____. <input type="checkbox"/> Return for Physician only in _____ week(s). <input type="checkbox"/> Last Cycle. Return in _____ week(s)		
<b>CBC &amp; Diff, Platelets</b> prior to each treatment If clinically indicated: <input type="checkbox"/> <b>Bilirubin</b> <input type="checkbox"/> <b>Creatinine</b> <input type="checkbox"/> <b>Tumour Markers:</b> <input type="checkbox"/> <b>Imaging Study:</b> <input type="checkbox"/> <b>Other tests:</b> <input type="checkbox"/> <b>Consults:</b> <input type="checkbox"/> See general orders sheet for additional requests.		
<b>DOCTOR'S SIGNATURE:</b>		<b>SIGNATURE:</b>
		<b>UC:</b>