PROTOCOL CODE: GIPGEM

DOCTOR'S ORDERS

Ht _____**cm** **Wt** _____**kg** **BSA** _____**m²**

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle/Week #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff, Platelets** day of treatment

May proceed with doses as written if within 48 hours **ANC greater than 1.0 x 10^9/L, Platelets greater than 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 _____.

☐ **prochlorperazine 10 mg** PO or ☐ **metoclopramide 10 mg** PO prior to treatment

☐ **Other:**

CHEMOTHERAPY: ☐ **Weekly x 7 weeks** **OR** ☐ **Weekly x 3 weeks** (select one)

gemcitabine 1000 mg/m² x BSA = _____mg

☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg

IV in 250 mL NS over 30 minutes

DOSE MODIFICATION IF REQUIRED ON SUBSEQUENT DAYS:

gemcitabine 1000 mg/m² x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg

IV in 250 mL NS over 30 minutes on days _____

RETURN APPOINTMENT ORDERS

☐ Book chemo weekly x _____ weeks

☐ Return in **four** or _____weeks for Doctor and Cycle _____.

☐ Return for Physician only in _____ week(s).

☐ Last Cycle. Return in _____ week(s)

CBC & Diff, Platelets prior to each treatment

If clinically indicated: ☐ **Bilirubin** ☐ **Creatinine**

☐ **Tumour Markers:**

☐ **Imaging Study:**

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: