

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_



CC1320 0003 06 2016

Weight: \_\_\_\_\_ kg      Height: \_\_\_\_\_ cm      Body Surface Area (BSA) = \_\_\_\_\_

**Allergies:**

**No Known**

Date: DD/MONTH/YYYY      Planned Administration Date: DD/MONTH/YYYY  
Cycle \_\_\_\_\_ of \_\_\_\_\_      **Cycle Duration: 28 days**      Date of previous cycle: DD/MONTH/YYYY

**MAY PROCEED WITH DOSES AS WRITTEN IF:**

- ANC **greater than or equal to**  $1.0 \times 10^9/L$  and platelets **greater than or equal to**  $100 \times 10^9/L$ , otherwise notify Medical Oncologist.
- LFT's and Bilirubin assessed.
- Creatinine clearance assessed

**PREMEDICATIONS (Start 1 hour pre-treatment)**

- Metoclopramide 10 mg PO
- Other: \_\_\_\_\_

**CHEMOTHERAPY:**

- Gemcitabine **1000 mg/m<sup>2</sup>** X BSA= \_\_\_\_\_ mg IV in 250 mLs NS over 30 minutes on days 1, 8, & 15
- Dose modification: **1000 mg/m<sup>2</sup>** X BSA - \_\_\_\_\_% = \_\_\_\_\_ mg IV in 250 mLs NS over 30 minutes on days 1, 8, & 15

Authorized Prescriber: \_\_\_\_\_ Date: DD/MONTH/YYYY Time: \_\_\_\_\_

Authorized Prescriber's Signature: \_\_\_\_\_

Nurse's Name: \_\_\_\_\_ Date: DD/MONTH/YYYY Time: \_\_\_\_\_

Nurse's Signature: \_\_\_\_\_

THIS IS A CONTROLLED DOCUMENT; PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION. USER WILL BE SOLELY RESPONSIBLE FOR VERIFYING ITS CURRENCY AND ACCURACY.