CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet
Gemcitabine **21** Day Regimen:
Gemcitabine
Adult Chemotherapy- Medical Oncology
Advanced Pancreatic Adenocarcinoma Therapy

CC1330 0004 06 2016

Name:

HCN:

Date of Birth:

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: 21 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

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

PREMEDICATIONS:

☐ **Metoclopramide 10 mg PO**

☐ Other: _____

CHEMOTHERAPY:

☐ **Gemcitabine 1000 mg/m^2** X BSA= _____mg IV in 250 mLs NS over 30 minutes on days 1 & 8

☐ Dose modification: **1000 mg/m^2** X BSA - _____ % = _____mg IV in 250 mLs NS over 30 minutes on days 1 & 8

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

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