CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

CISplatin **25** - Gemcitabine **1000** Regimen:

CISplatin - Gemcitabine (Part I)

Adult Chemotherapy- Medical Oncology

Advanced Gallbladder Cancer and Cholangiocarcinoma Therapy

CC1410 0012 06 2017

Name:

HCN:

Date of Birth:

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, platelets **greater than or equal to** 100 X 10^9/L, Creatinine Clearance **greater than or equal to** 60 mL/minute, otherwise notify Medical Oncologist.
- LFT's and Bilirubin assessed.

PREMEDICATIONS:

☐ **Ondansetron 16 mg PO on Days 1 & 8**

☐ **Dexamethasone 8 mg PO on Days 1 & 8**

☐ Other: _____

HYDRATION/SUPPPORTIVE CARE:

☐ **Normal Saline 500 mLs IV** pre-chemotherapy over 60 minutes

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

Authorized Prescriber's Signature: _____ ID #: _____

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

Nurse's Signature: _____

CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

CISplatin **25** - Gemcitabine **1000** Regimen:

CISplatin- Gemcitabine (Part II)

Adult Chemotherapy- Medical Oncology

Advanced Gallbladder Cancer and Cholangiocarcinoma Therapy Diagnosis

CC1410 0012 06 2017

Name:

HCN:

Date of Birth:

Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **CISplatin 25 mg/m²** X BSA = _____ mg IV in 250 mLs NS infused at 1 mg/minute on Days 1 & 8

☐ **Dose modification: 25 mg/m²** X BSA - _____% = _____ mg IV in 250 mLs NS infused at 1 mg/minute on Days 1 & 8

☐ **Gemcitabine 1000 mg/m²** X BSA = _____ mg IV in 250 mLs NS over 30 minutes on Days 1 & 8

☐ **Dose modification: 1000 mg/m²** X BSA - _____% = _____ mg IV in 250 mLs NS over 30 minutes on Days 1 & 8

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

Authorized Prescriber's Signature: _____ ID #: _____

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

Nurse's Signature: _____