CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

CARBOplatin **AUC 5** – gemcitabine **1000** Regimen:

CARBOplatin - gemcitabine

(Part I)

Name:

HCN:

Date of Birth:

ARIA Protocol Name: CarbAUC5 Gem 1000 D1 & 8

Adult Chemotherapy- Medical Oncology

Advanced Non-Small Cell Lung Cancer Therapy

C1910 0062 05 2020

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 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS:

☐ **ondansetron 16 mg PO on day 1**

☐ **dexamethasone 8 mg PO on day 1**

☐ **metoclopramide 10 mg PO on day 8**

☐ Other: _____

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

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

Authorized Prescriber's Signature: _____ ID #: _____

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.

CANCERCare
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Doctor's Order Sheet

CARBOplatin **AUC 5** - gemcitabine **1000** Regimen:

CARBOplatin - gemcitabine

(Part II)

Name:

HCN:

Date of Birth:

ARIA Protocol Name: CarbAUC5 Gem 1000 D1 & 8

Adult Chemotherapy- Medical Oncology

Advanced Non-Small Cell Lung Cancer Therapy

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

CHEMOTHERAPY:

☐ **gemcitabine 1000 mg/m²** X BSA = _____ mg IV in 250 mL normal saline over 30 minutes on days 1 & 8

☐ Dose modification: **1000 mg/m²** X BSA - _____% = _____ mg IV in 250 mL normal saline over 30 minutes on days 1 & 8

☐ **CARBOplatin AUC 5 = _____** mg IV in 250 mL normal saline over 30 minutes on day 1

☐ Dose modification: **AUC 5** - _____% =_____ mg IV in 250 mL normal saline over 30 minutes on day 1

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: _____DD/MONTH/YYYY_____Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: _____DD/MONTH/YYYY_____ Time: _____

Nurse's Signature: _____