

Doctor's Order Sheet

**CARBOplatin AUC 5 -
etoposide 100 Regimen**

ARIA Protocol Name: CarbAUC5 Etop100 D1,2,3

Adult Chemotherapy - Medical Oncology

Advanced Small Cell Genitourinary Cancer Therapy



CC3050 0116 07 2020

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** $1.5 \times 10^9/L$ and platelets **greater than or equal to** $100 \times 10^9/L$, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

- ☐ ondansetron **16 mg PO** on days 1 to 3
- ☐ dexamethasone **8 mg PO** on days 1 to 3
- ☐ Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

- ☐ **CARBOplatin AUC 5** = _____ mg
- ☐ Dose modification: **CARBOplatin AUC 5** - _____ % = _____ mg
- IV** in 250 mL normal saline over 30 minutes on day 1
- ☐ **etoposide 100 mg/m² X BSA** = _____ mg
- ☐ Dose modification: **etoposide 100 mg/m² X BSA** - _____ % = _____ mg
- IV** in 500 mL normal saline PVC Free bag over 45 minutes on days 1 to 3

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.