CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

CARBOplatin AUC 5 - gemcitabine 1000 (28 day)

Regimen (Part I)

ARIA Protocol Name: CarbAUC5 Gem 1000 Day 1,8 and 15 Q28
Adult Chemotherapy - Medical Oncology
Urothelial Cancer Therapy

CC3070 0118 07 2020

Name:

HCN:

Date of Birth:

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** 1.5 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 (FOR HOSPITAL PHARMACY):

☐ **ondansetron 16 mg PO** on day 1
☐ **dexamethasone 8 mg PO** on day 1
☐ **metoclopramide 10 mg PO** on days 8 and 15
☐ 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.

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Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

CARBOplatin AUC 5 - gemcitabine 1000 (28 day)

Regimen (Part II)

ARIA Protocol Name: CarbAUC5 Gem 1000 Day 1,8 and 15 Q28

Adult Chemotherapy - Medical Oncology

Urothelial Cancer Therapy

CC3070 0118 07 2020

Weight: _________kg Height:________________________cm Body Surface Area (BSA) = ______________

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **gemcitabine 1000 mg/m²** X BSA = ___________ **mg**

☐ Dose modification: **gemcitabine 1000 mg/m²** X BSA - _________% = ___________ **mg**

IV in 250 mL normal saline over 30 minutes on days 1, 8 and 15

☐ **CARBOplatin AUC 5 =** ___________ **mg**

☐ Dose modification: **CARBOplatin 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: ____

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