

Doctor's Order Sheet
**CARBOplatin AUC 5 -
gemcitabine 800 Regimen**
(Part I)

Name: _____

HCN: _____

Date of Birth: _____

ARIA Protocol Name: Carb AUC5 Gem 800 D1 & 8

Adult Chemotherapy - Gynecologic Oncology

Epithelial Ovarian, Primary Peritoneal, or Fallopian Tube Carcinoma Therapy



CC3620 0173 01 2022

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** $1 \times 10^9/L$ and platelets **greater than or equal to** $100 \times 10^9/L$, otherwise notify Gynecologic Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

ondansetron 8 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: _____

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Doctor's Order Sheet

**CARBOplatin AUC 5 -
gemcitabine 800 Regimen**

(Part II)

ARIA Protocol Name: Carb AUC5 Gem 800 D1 & 8

Adult Chemotherapy - Gynecologic Oncology

Epithelial Ovarian, Primary Peritoneal, or Fallopian Tube Carcinoma Therapy



CC3620 0173 01 2022

Name: _____

HCN: _____

Date of Birth: _____

Weight: _____ kg Height: _____ cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

- gemcitabine 800 mg/m² X BSA = _____ mg (maximum dose 2000 mg)**
 - Dose modification: **gemcitabine 800 mg/m² X BSA - _____ % = _____ mg (maximum dose 2000 mg)**
 - IV in 250 mL normal saline over 30 minutes on days 1 and 8**

- 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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