



Doctor's Order Sheet  
**CARBOplatin AUC 5**  
Regimen

**ARIA Protocol Name:** Carb AUC5  
Adult Chemotherapy - Gynecologic Oncology  
Uterine, Epithelial Ovarian, Primary Peritoneal,  
or Fallopian Tube Carcinoma Therapy



CC2120 0083 08 2021

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Allergies:**

**No Known**

Date: DD/MONTH/YYYY

Cycle \_\_\_\_\_ of \_\_\_\_\_

**Cycle Duration: 21 days**

Planned Administration Date: DD/MONTH/YYYY

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

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

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.