

Doctor's Order Sheet  
**gemcitabine 100 Regimen**  
**ARIA Protocol Name:** Gemcitabine Weekly  
 Adult Chemotherapy - Medical Oncology  
 Muscle Invasive Bladder Cancer

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

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

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



CC7270 0547 04 2025

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: 28 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 Medical Oncologist.
- Creatinine Clearance assessed.
- LFTs and Bilirubin assessed.

**PREMEDICATIONS (FOR HOSPITAL PHARMACY):**

- metoclopramide 10 mg PO** on day 1, 8, 15 and 22
- Other: \_\_\_\_\_

**CHEMOTHERAPY (FOR HOSPITAL PHARMACY):**

- gemcitabine 100 mg/m<sup>2</sup>** X BSA = \_\_\_\_\_ **mg**
- Dose modification: **gemcitabine 100 mg/m<sup>2</sup>** X BSA - \_\_\_\_\_ % = \_\_\_\_\_ **mg**
- IV** in 250 mL normal saline over 30 minutes on day 1, 8, 15 and 22

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.