Follow-up appt.: ___________________________________ with labs _________________________

Specific Administration Instructions/Requirements:
1. Institute extravasation protocol in the event of a suspected extravasation
   □ ANC greater than 1,000  □ ANC greater than 1,500  □ Platelets greater than 100,000
2. Monitor for hypersensitivity / allergic reaction. If suspected, then follow hypersensitivity / anaphylaxis orders per the Emergency Physician’s Order protocol.

Labs:
□ CBC w/diff  □ CMP  □ BMP  □ LFT  □ Other: _____________________________________________

Pre-Medications (please check appropriate meds):
1. Diphenhydramine 50 mg IV x 1 dose Days 1, 8, 15 and 22  
2. Dexamethasone 12 mg IV x 1 dose Days 1, 8, 15 and 22  
3. Ranitidine 50 mg IV x 1 dose Days 1, 8, 15 and 22

Take Home Medications (please check appropriate meds):
□ Lorazepam 1 mg IV PRN anxiety or nausea x 1 dose  □ Prochlorperazine 10 mg IV PRN nausea and vomiting x 1 dose  
□ Promethazine 25 mg IV PRN nausea and vomiting x 1 dose  
□ Prochlorperazine 10 mg PO every 6 hours PRN nausea and vomiting (# __________) OR  
□ Promethazine 25 mg PO every 6 hours PRN nausea and vomiting (# __________)

Special Instructions / Extra Orders: ______________________________________________________________

Date __________  Time __________  Signature of Oncology Attending/Fellow ____________________________________________ MD

Print Name of Attending / Fellow: ___________________________________________  MD# __________________

Chemotherapy:

<table>
<thead>
<tr>
<th>DRUG (Oral or injectable)</th>
<th>PROTOCOL DOSAGE (Per m² or Per kg)</th>
<th>PATIENT’S DOSE</th>
<th>ROUTE / FREQUENCY</th>
<th>GIVE ON DAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paclitaxel</td>
<td>80 mg/m²</td>
<td>IV</td>
<td></td>
<td>Days 1, 8, 15 and 22</td>
</tr>
<tr>
<td>Fluid / Volume: 250 mL NS</td>
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<td>Flow Rate or Infusion Time: 1 hour</td>
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Follow-up appt.: ___________________________________ with labs _________________________

Date __________  Time __________  Physician/PA/RPh _________________________________  Provider# ______________  Beeper# ________________

Date __________  Time __________  Signature of Oncology Attending/Fellow ___________________________________________________________________________ MD

Print Name of Attending / Fellow: ___________________________________________  MD# __________________