PROVIS

Provis Patient No.

MEDICATION ORDER FORM

Gemcitabine (Gemzar ™)

Patient's Surname	**Given Name & Initials**	**Date of Birth**
		_____ / _____ / _____ dd mm yyyy

Referring MD/Oncologist

Required parameters for full dose
DO NOT PROCEED with chemotherapy if

neutrophils	<1.5 x 10^9/L	**Or**	neutrophils: ……..
platelets	<100 x 10^9/L		platelets: ……..
Hb	< 70		Hb: ……..

If parameters are not met, please contact

Dr. Tel.: for patient assessment.

Patient's Height: _____ cm Weight: _____ kg BSA: _____ m^2	Dose Reduction? Yes ☐ No ☐ Reason_____ Cycle:

Pre-Medication

Dexamethasone 10 mg IV pre-chemotherapy on days 1, 8, 15 ☐
Prochlorperazine 10 mg PO pre-chemotherapy on days 1, 8, 15 ☐
Other ☐

- **Monitor Vitals prior and post dose with each dose.**

Medication prescribed

Gemcitabine _____ mg (1,000 mg / m^2)
in 250 mL NS IV over 30 minutes on days 1, 8, 15; then 1 week off
.

(For Provis Use Only)

Day 1: _____

Day 8: _____

Day 15: _____

Scheduled Frequency

Repeat every 4 weeks

Physician's Signature (Referring Oncologist)	_____ / _____ / _____ dd mm yyyy
Signature of Provis Physician	_____ / _____ / _____ dd mm yyyy

Repeat Order:

Each cycle requires a new medication order.

Fax completed form to: 416-532-3635