



Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BCCA treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care.

PROTOCOL CODE: SAAVADIC

DOCTOR'S ORDERS		Ht _____ cm	Wt _____ kg	BSA _____ m ²
REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form				
DATE:	To be given:	Cycle #:		
Date of Previous Cycle: _____				
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, Platelets day of treatment May proceed with doses as written if within 96 hours ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____				
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____. Ondansetron 8 mg PO prior to treatment Dexamethasone 8 mg or 12 mg (circle one) PO prior to treatment <input type="checkbox"/> Aprepitant 125 mg PO pre-chemotherapy on day 1 and 80 mg PO post-chemotherapy once daily on days 2 and 3				
CHEMOTHERAPY: Doxorubicin 60 mg/m² or _____ mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg IV push. Dacarbazine 850 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg IV in 500 mL NS over 1 hour				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in three weeks for Cycle _____. <input type="checkbox"/> Last Cycle. Return in _____ weeks.				
CBC & Diff, Platelets, AST, Alk Phos, Bilirubin, GGT, LDH prior to each treatment. <input type="checkbox"/> CXR <input type="checkbox"/> Other Tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:			SIGNATURE:	
			UC:	