



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](http://www.bccancer.bc.ca) and according to acceptable standards of care.

PROTOCOL CODE: KSVB

<b>DOCTOR'S ORDERS</b>		Ht _____ cm	Wt _____ kg	BSA _____ m <sup>2</sup>
<b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>				
<b>DATE:</b> _____	<b>To be given:</b> _____	<b>Cycle #:</b> _____		
Date of Previous Cycle: _____				
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff, Platelets</b> day of treatment May proceed with doses as written if within 24 hours <input type="checkbox"/> <b>ANC greater than or equal to</b> _____ x 10 <sup>9</sup> /L, Platelets <b>greater than or equal to</b> _____ x 10 <sup>9</sup> /L or <input type="checkbox"/> <b>ANC greater than 1</b> x 10 <sup>9</sup> /L, Platelets <b>greater than</b> 74 x 10 <sup>9</sup> /L (Vinblastine Only) Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____ Proceed with treatment based on blood work from _____				
<b>PREMEDICATIONS:</b> <input type="checkbox"/> Patient to take own supply. RN/Pharmacist to confirm _____ <input type="checkbox"/> <b>Prochlorperazine 10 mg</b> PO pre-chemotherapy PRN   OR <input type="checkbox"/> <b>Metoclopramide 10 mg</b> PO pre-chemotherapy PRN <input type="checkbox"/> <b>Hydrocortisone 100 mg</b> IV pre-Bleomycin				
<b>CHEMOTHERAPY:</b> <b>DAY 1:</b> <input type="checkbox"/> <b>Vinblastine</b> (circle one) <b>6 mg, 10 mg, or</b> _____ mg <input type="checkbox"/> <b>Dose Modification:</b> ( _____ %) = _____ mg IV push <b>If Neutropenia, omit Vinblastine</b> Substitute <b>Bleomycin 10 units/m<sup>2</sup> x BSA</b> = _____ units <input type="checkbox"/> <b>Dose Modification:</b> ( _____ %) = _____ units/m <sup>2</sup> x BSA = _____ units IV in 50 mL NS over at least 10 minutes  <b>DAY 8:</b> <input type="checkbox"/> <b>Vincristine 1 mg</b> <input type="checkbox"/> <b>Dose Modification:</b> ( _____ %) = _____ mg IV in 50 mL NS over 15 mins. <b>If neurological dysfunction, omit Vincristine</b> Substitute <b>Bleomycin 10 units/m<sup>2</sup> x BSA</b> = _____ units <input type="checkbox"/> <b>Dose Modification:</b> ( _____ %) = _____ units/m <sup>2</sup> x BSA = _____ units IV in 50 mL NS over at least 10 minutes  <b>OR</b> <b>Methotrexate 25 mg/m<sup>2</sup> x BSA</b> = _____ mg <input type="checkbox"/> <b>Dose Modification:</b> _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV push				
<b>RETURN APPOINTMENT ORDERS</b>				
<input type="checkbox"/> Return in _____ weeks for Doctor and Cycle _____ ((Book Chemo Day 1 and 8) <input type="checkbox"/> Last Cycle. Return in _____ week(s).				
<b>CBC prior to each cycle (if Vinblastine OR Methotrexate being used)</b> <b>CR (only required if using Bleomycin and Methotrexate)</b> If clinically indicated: <input type="checkbox"/> <b>Tot. Prot</b> <input type="checkbox"/> <b>Albumin</b> <input type="checkbox"/> <b>Bilirubin</b> <input type="checkbox"/> <b>GGT</b> <input type="checkbox"/> <b>Alk Phos.</b> <input type="checkbox"/> <b>AST</b> <input type="checkbox"/> <b>LDH</b> <input type="checkbox"/> <b>ALT</b> <input type="checkbox"/> <b>BUN</b> <input type="checkbox"/> <b>Creatinine</b>  <input type="checkbox"/> <b>Other tests:</b> <input type="checkbox"/> <b>Consults:</b> <input type="checkbox"/> <b>See general orders sheet for additional requests.</b>				
<b>DOCTOR'S SIGNATURE:</b>				<b>SIGNATURE:</b>
				UC: