BC Cancer Agency
CARE & RESEARCH

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: LYIT

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:

☐ Delay treatment _______ week(s)

☐ **CBC & Diff and Platelets** prior to day 1, 8 and 15 of treatment

May proceed with doses as written if within 24 hours **ANC greater than or equal to 0.5 x 10^9/L, Platelets greater than or equal to 40 x 10^9/L**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** ______________________________

Proceed with treatment based on blood work from ____

INTRATHECAL (IT) CHEMOTHERAPY:

Methotrexate _________mg IT (standard dose 12 mg) on Days 1, 8 and 15.

Cytarabine _________mg IT (standard dose 50 mg) on Days 4, 11 and 18.

RETURN APPOINTMENT ORDERS

☐ Return in ________ weeks for Doctor and Cycle __________.

Book chemo Days 1, 4, 8, 11, 15 and 18 q 3 weeks.

☐ Last Cycle. Return in ________ week(s).

CBC & Diff, Platelets prior to Days 1, 8 and 15.

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

MEDICATION VERIFICATION CHECKS
Full Signatures Required

Medication/Route	Day 1	Day 4	Day 8	Day 11	Day 15	Day 18
Date (dd/mm/yy)						
Methotrexate 12mg IT	(RN) (MD)	**Not Given**	(RN) (MD)	**Not Given**	(RN) (MD)	**Not Given**
Cytarabine 50mg IT	**Not Given**	(RN) (MD)	**Not Given**	(RN) (MD)	**Not Given**	(RN) (MD)