



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: LYCYCLO

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 1.2 x 10 ⁹ /L, Platelets greater than 80 x 10 ⁹ /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"/> Other: _____				
CHEMOTHERAPY: IV Cyclophosphamide _____ mg/m ² = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 100 to 250 mL NS over 20 minutes to 1 hour. OR Oral Cyclophosphamide _____ mg/m ² /day = _____ mg PO daily x 5 days. (Round dose to nearest 25 mg) OPTIONAL: Prednisone 45 mg/m²/day = _____ mg PO daily in the AM with food x 5 days. (Round dose to nearest 25 mg)				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____				
<input type="checkbox"/> Last Cycle. Return in _____ week(s).				
CBC & Diff, Platelets prior to each cycle <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:		SIGNATURE:		
		UC:		