



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: LUAVVIN

<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 <b>ANC greater than or equal to 1 x 10<sup>9</sup>/L,</b> <b>Platelets greater than 100 x 10<sup>9</sup>/L</b>  Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____ <b>Proceed with treatment based on blood work from</b> _____				
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____. <input type="checkbox"/> <b>Hydrocortisone 100 mg IV prn</b> <input type="checkbox"/> <b>Other:</b> _____				
<b>CHEMOTHERAPY:</b>  <b>Vinorelbine 30 mg/m<sup>2</sup>/day</b> x BSA = _____ mg <input type="checkbox"/> <b>Dose Modification:</b> _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 50 mL NS over 6 minutes <b>Day 1 and Day 8</b>  Flush vein with 75 to 125 mL NS following infusion of Vinorelbine.				
<b>DOSE MODIFICATION DAY 8:</b>  <b>Vinorelbine 30 mg/m<sup>2</sup>/day</b> x BSA = _____ mg <input type="checkbox"/> <b>Dose Modification:</b> _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 50 mL NS over 6 minutes <b>Day 8</b>  Flush vein with 75 to 125 mL NS following infusion of Vinorelbine				
<b>RETURN APPOINTMENT ORDERS</b>				
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____. Book chemo Day 1 and 8. <input type="checkbox"/> Last Cycle. Return in _____ week(s).				
<b>CBC &amp; Diff, Platelets</b> prior to each treatment If clinically indicated prior to each cycle: <input type="checkbox"/> <b>Creatinine</b> <input type="checkbox"/> <b>Bilirubin</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>				
DOCTOR'S SIGNATURE:		SIGNATURE:		
		UC:		