



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: ULUOTPAC

A BCCA "Compassionate Access Program" request form must be completed and approved prior to treatment.

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, Creatinine Clearance greater than or equal to 60 mL/min.				
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 (<i>circle one</i>) 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				
HYDRATION: 1000 mL NS over 60 minutes prior to cisplatin				
CHEMOTHERAPY:				
Doxorubicin 50 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____% = _____ mg/m ² x BSA = _____ mg IV push (may be given during hydration)				
Cisplatin 50 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____% = _____ mg/m ² x BSA = _____ mg IV in 500 mL NS with potassium chloride 20 mEq, magnesium sulfate 1 g, and Mannitol 30 g over 1 hour				
Cyclophosphamide 500 mg/m² x BSA = _____ 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				
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, Creatinine prior to each cycle				
If clinically indicated: <input type="checkbox"/> Bilirubin				
<input type="checkbox"/> Other tests:				
<input type="checkbox"/> Consults:				
<input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:		SIGNATURE:		
		UC:		