



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: BRAJFEC

| | | | | |
|--|---------------------|-----------------|-------------|--------------------------|
| 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 <u>greater than or equal to</u> 1.5 x 10⁹/L, Platelets <u>greater than or equal to</u> 100 x 10⁹/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"/> Hydrocortisone 100 mg IV PRN <input type="checkbox"/> Other: | | | | |
| CHEMOTHERAPY: Epirubicin 100 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV push Fluorouracil 500 mg/m² x BSA x = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV push 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 _____ weeks. | | | | |
| CBC & Diff, platelets prior to each cycle. If clinically indicated: <input type="checkbox"/> Bilirubin <input type="checkbox"/> Creatinine <input type="checkbox"/> Muga Scan <input type="checkbox"/> Echocardiogram <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests. | | | | |
| DOCTOR'S SIGNATURE: | | SIGNATURES: | | |
| | | UC: | | |