



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: BRAVAC

|  |                     |                 |             |                          |
|--|---------------------|-----------------|-------------|--------------------------|
| <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)<br><input type="checkbox"/> <b>CBC &amp; Diff, platelets</b> on day of treatment  |                     |                 |             |                          |
| May proceed with doses as written if within 96 hours <b>ANC <u>greater than or equal to</u> 1.5 x 10<sup>9</sup>/L, Platelets <u>greater than or equal to</u> 90 x 10<sup>9</sup>/L</b><br>Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____<br><b>Proceed with treatment based on blood work from</b> _____                                    |                     |                 |             |                          |
| PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.<br><b>Ondansetron 8 mg</b> PO prior to treatment<br><b>Dexamethasone 8 mg or 12 mg</b> (circle one) PO prior to treatment<br><input type="checkbox"/> Other  |                     |                 |             |                          |
| CHEMOTHERAPY:<br><br><b>Doxorubicin 60 mg/m<sup>2</sup></b> x BSA = _____ mg<br><input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg<br>IV push<br><br><b>Cyclophosphamide 600 mg/m<sup>2</sup></b> x BSA = _____ mg<br><input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg<br>IV in 100 to 250 mL NS over 20 minutes to 1 hour |                     |                 |             |                          |
| <b>RETURN APPOINTMENT ORDERS</b>   |                     |                 |             |                          |
| <input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____   |                     |                 |             |                          |
| <input type="checkbox"/> Last Cycle. Return in _____ week(s)   |                     |                 |             |                          |
| <b>CBC &amp; Diff, Platelets</b> prior to each cycle.<br>If clinically indicated: <input type="checkbox"/> <b>Creatinine</b> <input type="checkbox"/> <b>Bilirubin</b><br><input type="checkbox"/> <b>Other tests:</b><br><br><input type="checkbox"/> <b>Consults:</b><br><br><input type="checkbox"/> <b>See general orders sheet for additional requests.</b>   |                     |                 |             |                          |
| DOCTOR'S SIGNATURE:  |                     |                 | SIGNATURE:  |                          |
|  |                     |                 | UC:         |                          |