



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: BRAVNAV

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 24 hours ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 90 x 10⁹/L Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> ECOG <input type="checkbox"/> Other Toxicity Proceed with treatment based on blood work from _____				
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.				
<input type="checkbox"/> Prochlorperazine 10 mg PO prior to treatment <input type="checkbox"/> Metoclopramide 10 – 20 mg PO prior to treatment <input type="checkbox"/> Hydrocortisone 100 mg IV in 50 mL NS over 20 minutes pre-Vinorelbine (for patients who have had previous phlebitis) <input type="checkbox"/> Other:				
CHEMOTHERAPY:				
DAY 1 and 8				
Vinorelbine 30 mg/m²/day or 25 mg/m²/day (circle one) x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² /day x BSA = _____ mg IV in 50 mL NS over 6 minutes on Day 1 and Day 8. Flush vein with 75 to 125 mL NS following infusion of Vinorelbine				
OR				
DOSE MODIFICATION REQUIRED ON DAY 8				
Vinorelbine 30 mg/m²/day or 25 mg/m²/day (circle one) x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² /day x BSA = _____ mg IV in 50 mL NS over 6 minutes. Flush vein with 75 to 125 mL NS following infusion of Vinorelbine				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____. Book chemo room Day 1 and Day 8 <input type="checkbox"/> Last Cycle. Return in _____ weeks.				
CBC & Diff, platelets prior to each treatment 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: