



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: BRAJCAFPO

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 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"/> Other: _____				
CHEMOTHERAPY: DAY 1 & 8 Doxorubicin 30 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV push on Day 1 and 8 Fluorouracil 500 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV push on Day 1 and 8 Cyclophosphamide 100 mg/m²/day x BSA x (_____ %) = _____ mg PO daily on Days 1 to 14 . (Round dose to nearest 25 mg)				
OR				
DOSE MODIFICATION REQUIRED ON DAY 8 Doxorubicin 30 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV push on Day 8 Fluorouracil 500 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV push on Day 8 Cyclophosphamide 100 mg/m²/day x BSA x (_____ %) = _____ mg PO daily on Days 8 to 14 . (Round dose to nearest 25 mg)				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in four weeks for Doctor and Cycle _____. Book chemo room Day 1 and 8 <input type="checkbox"/> Last Cycle. Return in _____ week(s).				
CBC & Diff, platelets prior to each treatment If clinically indicated: <input type="checkbox"/> Bilirubin <input type="checkbox"/> Creatinine <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:			SIGNATURES:	
			UC:	