BC Cancer Agency
CARE & RESEARCH

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: BRAVCMF

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:

☐ Delay treatment _____ week(s)

☐ **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 10^9/L, Platelets greater than or equal to 90 x 10^9/L**

Dose modification for: ☐ **Hematology** ☐ **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

☐ **Other:**

CHEMOTHERAPY:

Methotrexate 40 mg/m^2 x BSA =_____mg

☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg

IV push

Fluorouracil 600 mg/m^2 x BSA =_____mg

☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg

IV push

Cyclophosphamide 600 mg/m^2 x BSA = _____mg

☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg

IV in 100 to 250 mL NS over 20 minutes to 1 hour

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____

☐ Last Cycle. Return in _____weeks.

CBC & Diff, Platelets prior to each cycle

If clinically indicated: ☐ **Bilirubin** ☐ **AST** ☐ **Creatinine**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: