



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: GOOVCATX

<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) <input type="checkbox"/> <b>CBC &amp; Diff, Platelets</b> day of treatment May proceed with doses as written if within 96 hours <b>ANC <u>greater than or equal to</u> 1 x 10<sup>9</sup>/L, Platelets <u>greater than or equal to</u> 100 x 10<sup>9</sup>/L</b> Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____ <b>Proceed with treatment based on blood work from</b> _____				
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.				
<b>45 minutes prior to Paclitaxel:</b> Dexamethasone 20 mg IV in 50 mL NS over 15 minutes				
<b>30 minutes prior to Paclitaxel:</b> Diphenhydramine 50 mg IV and Ranitidine 50 mg IV in 50 mL NS over 20 minutes				
Ondansetron 8 mg PO 30 minutes prior to Carboplatin.				
<input type="checkbox"/> <b>Other:</b>				
<b>**Have Hypersensitivity Reaction Tray and Protocol Available**</b>				
CHEMOTHERAPY:				
Paclitaxel 175 mg/m <sup>2</sup> OR _____ mg/m <sup>2</sup> (circle one) x BSA = _____ mg				
<input type="checkbox"/> <b>Dose Modification:</b> _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg				
IV in 250 to 500 mL (non-PVC bag) NS over 3 hours. (Use non-PVC tubing with in-line filter)				
Carboplatin AUC 6 or 5 (circle one) x (GFR + 25) = _____ mg				
<input type="checkbox"/> <b>Dose Modification:</b> _____ % = _____ mg				
IV in 250mL D5W over 30 minutes.				
<b>RETURN APPOINTMENT ORDERS</b>				
Return in <input type="checkbox"/> <b>three</b> weeks, or <input type="checkbox"/> <b>four</b> weeks for Doctor and Cycle _____				
<input type="checkbox"/> Last Treatment. Return in _____ week(s).				
<b>CBC &amp; Diff, Platelets</b> on <input type="checkbox"/> Day 14 <input type="checkbox"/> Day 21. <b>CBC &amp; Diff, Platelets</b> prior to each cycle. Prior to next cycle, if clinically indicated: <input type="checkbox"/> <b>Bilirubin</b> <input type="checkbox"/> <b>Alk Phos</b> <input type="checkbox"/> <b>GGT</b> <input type="checkbox"/> <b>ALT</b> <input type="checkbox"/> <b>AST</b> <input type="checkbox"/> <b>LDH</b> <input type="checkbox"/> <b>Tot Prot</b> <input type="checkbox"/> <b>Albumin</b> <input type="checkbox"/> <b>Creatinine</b> <input type="checkbox"/> <b>CA 15-3</b> <input type="checkbox"/> <b>CA 125</b> <input type="checkbox"/> <b>CA 19-9</b>				
<input type="checkbox"/> <b>Other tests:</b>				
<input type="checkbox"/> <b>Consults:</b>				
<input type="checkbox"/> <b>See general orders sheet for additional requests.</b>				
DOCTOR'S SIGNATURE:				SIGNATURE:
				UC: