



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: GUSCARB

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 <u>greater than or equal to</u> 1.2 x 10⁹/L, Platelets <u>greater than or equal to</u> 120 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 (<i>circle one</i>) prior to treatment <input type="checkbox"/> Other: _____		
Have Hypersensitivity Reaction Tray and Protocol Available		
CHEMOTHERAPY: Carboplatin AUC 7 x (GFR + 25) = _____ mg IV in 250 mL D5W over 30 minutes		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in four weeks for Doctor and Cycle _____		
<input type="checkbox"/> Last Cycle. Return in _____ week(s).		
CBC & Diff, Platelets, Creatinine prior to each cycle <input type="checkbox"/> CBC & Diff, Platelets Day 14 and Day 21 If clinically indicated: <input type="checkbox"/> AST, ALT, Alk Phos, Bili, LDH <input type="checkbox"/> Other tests: _____ <input type="checkbox"/> Consults: _____ <input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:	SIGNATURE:	
	UC:	