



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: UGUEVER

A BCCA "Compassionate Access Program" request form must be completed and approved prior to treatment

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 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/L Proceed with treatment based on blood work from _____				
Treatment:				
Everolimus 10 mg or 5 mg PO on an empty stomach or after a fat-free meal daily. Mitte: _____ days				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in _____ weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Cycle. Return in _____ week(s).				
CBC & Diff, Platelets prior to each cycle If clinically indicated: <input type="checkbox"/> Tot. Prot <input type="checkbox"/> Albumin <input type="checkbox"/> Bilirubin <input type="checkbox"/> GGT <input type="checkbox"/> Alk Phos. <input type="checkbox"/> AST <input type="checkbox"/> LDH <input type="checkbox"/> ALT <input type="checkbox"/> BUN <input type="checkbox"/> Creatinine <input type="checkbox"/> Glucose <input type="checkbox"/> Tot. cholesterol <input type="checkbox"/> Triglycerides <input type="checkbox"/> Lytes				
<input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:			SIGNATURE:	
			UC:	