



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: GUPMX

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 90 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 _____.					
<input type="checkbox"/> Metoclopramide 10 mg PO prior to treatment <input type="checkbox"/> Prochlorperazine 10 mg PO prior to treatment <input type="checkbox"/> Other: _____					
CHEMOTHERAPY:					
Mitoxantrone 12 mg/m² or _____ mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg IV in 50 mL NS over 5 minutes					
Prednisone <input type="checkbox"/> 10 mg PO daily or <input type="checkbox"/> 5 mg PO bid <div style="text-align: center;">mitte 42 tablets</div>					
RETURN APPOINTMENT ORDERS					
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____					
<input type="checkbox"/> Last Cycle. Return in _____ week(s).					
CBC & Diff, Platelets, PSA prior to each cycle If clinically indicated: <input type="checkbox"/> Bilirubin					
<input type="checkbox"/> Other tests:					
<input type="checkbox"/> Consults:					
<input type="checkbox"/> See general orders sheet for additional requests.					
DOCTOR'S SIGNATURE:			SIGNATURE:		
			UC:		