



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: **HNNAVFUFA**

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 $1.5 \times 10^9/L$, Platelets greater than or equal to $100 \times 10^9/L$ 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 _____.		
CHEMOTHERAPY:		
Leucovorin 20 mg/m² x BSA = _____ mg IV push prior to Fluorouracil weekly x _____ weeks. Fluorouracil 500 mg/m² x BSA x (_____ %) = _____ mg IV push weekly x _____ weeks.		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in two or four (<i>circle one</i>) weeks for Doctor and Cycle _____. Book chemo x _____ weeks.		
<input type="checkbox"/> Last Cycle. Return in _____ week(s).		
CBC & Diff, Platelets every two weeks. IF clinically indicated: <input type="checkbox"/> Bilirubin, AST, alkaline phosphatase <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:	SIGNATURE:	
	UC:	