



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: HNAVM

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 1.5 x 10⁹/L, Platelets greater than 150 x 10⁹/L Caution if creatinine clearance is less than 80 ml/min. See dose modifications for Renal Dysfunction.				
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:				
One cycle = 1 week				
Methotrexate _____ mg/m ² x BSA x (_____ %) = _____ mg IV push once weekly x 2 weeks				
OR				
Methotrexate _____ mg/m ² x BSA x (_____ %) = _____ mg PO twice weekly for 2 weeks. (Round dose to nearest 2.5 mg)				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in _____ weeks for Doctor and Cycle _____. Book chemo weekly for at least 2 weeks.				
<input type="checkbox"/> Last Cycle. Return in _____ week(s).				
CBC & Diff, Platelets every two weeks				
<input type="checkbox"/> Serum Creatinine monthly				
<input type="checkbox"/> Other tests:				
<input type="checkbox"/> Consults:				
<input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:			SIGNATURE:	
			UC:	