



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](http://www.bccancer.bc.ca) and according to acceptable standards of care.

PROTOCOL CODE: GIAVCAP (PO)

**Class II Drug:**

First line metastatic or unresectable colorectal adenocarcinoma in a patient not suitable for infusional Fluorouracil, either alone (GIFUINF) or in combination with Irinotecan (GIFOLFIRI) or Oxaliplatin (UGIFOLFOX)

For other indications or for more than 16 cycles, a BCCA "Compassionate Access Program" request form must be completed and approved prior to treatment.

<b>DOCTOR'S ORDERS</b>			Ht _____ cm	Wt _____ kg	BSA _____ m <sup>2</sup>
<b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>					
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle(s) #:</b>			
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 <b>ANC greater than or equal to <math>1.5 \times 10^9/L</math>, Platelets greater than or equal to <math>75 \times 10^9/L</math>, Creatinine Clearance greater than 50 mL/minute</b>					
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Age/ECOG <input type="checkbox"/> Other Toxicity _____					
<b>Proceed with treatment based on blood work from _____</b>					
CHEMOTHERAPY: <input type="checkbox"/> Repeat in three weeks					
<b>Capecitabine 1250 or 1000 mg/m<sup>2</sup> (circle one) x BSA x ( _____ %) = _____ mg PO bid with food x 14 days</b> (Round dose to nearest 150 mg)					
<b>RETURN APPOINTMENT ORDERS</b>					
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____ <input type="checkbox"/> Return in <b>six</b> weeks for Doctor and Cycle _____ & _____. <input type="checkbox"/> Last Cycle. Return in _____ week(s)					
<b>CBC &amp; Diff, Platelets &amp; Creatinine</b> prior to each cycle  If clinically indicated: <input type="checkbox"/> BUN <input type="checkbox"/> Total Protein <input type="checkbox"/> Albumin <input type="checkbox"/> Bilirubin <input type="checkbox"/> Alk Phos <input type="checkbox"/> GGT <input type="checkbox"/> ALT  <input type="checkbox"/> Other tests:					
<input type="checkbox"/> Weekly Nursing Assessment <input type="checkbox"/> Consults:					
<input type="checkbox"/> See general orders sheet for additional requests.					
DOCTOR'S SIGNATURE:					SIGNATURE:
					UC: