



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.

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DOCTOR'S ORDERS

Ht _____ cm Wt _____ kg BSA _____ m²

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: _____ **To be given:** _____ **Cycle #:** _____

Date of Previous Cycle: _____

Delay treatment _____ week(s)

CBC & Diff, Platelets day of treatment

May proceed with doses as written for Cycle 1, 2, 4 & 5 if within 96 hours **ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L**

May proceed with doses as written for Cycle 3 if within 24 hours **ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/L**

Dose modification for: **Hematology** **Other Toxicity** _____

Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

Ice Chips – See Protocol

Metoclopramide 10-20 mg PO prior to treatment

Prochlorperazine 10 mg PO prior to treatment

Other: _____

RN to assess for stomatitis and diarrhea prior to EACH chemotherapy treatment

Notify Doctor if any signs and symptoms of toxicity

CHEMOTHERAPY:

Cycle 1, 4 or 5 (Circle One)

Leucovorin 20 mg/m² x BSA = _____ mg IV push daily x **5** days prior to Fluorouracil

Fluorouracil 425 mg/m² x BSA = _____ mg

Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg
IV push daily x **5** days

Cycle 2: First 4 days of RT

Leucovorin 20 mg/m² x BSA = _____ mg IV push daily x **4** days prior to Fluorouracil

Fluorouracil 400 mg/m² x BSA = _____ mg

Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg
IV push daily x **4** days

Cycle 3: Last 3 days of RT

Leucovorin 20 mg/m² x BSA = _____ mg IV push daily x **3** days prior to Fluorouracil

Fluorouracil 400 mg/m² x BSA = _____ mg

Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg
IV push daily x **3** days

DOCTOR'S SIGNATURE: _____



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RETURN APPOINTMENT ORDERS	
<input type="checkbox"/> Return in _____ weeks for Doctor and Cycle _____. Book chemo x 3, 4 or 5 days (<i>circle one</i>)	
<input type="checkbox"/> Return 5 th Monday after XRT completed for Cycle 4 chemo x 5 days	
<input type="checkbox"/> Last Cycle. Return in _____ week(s)	
CBC & Diff, Platelets prior to each cycle	
<input type="checkbox"/> CBC & Diff, Platelets weekly during radiation therapy	
<input type="checkbox"/> Other tests:	
<input type="checkbox"/> Radiation consult before Cycle _____ or in _____ weeks	
<input type="checkbox"/> See general orders sheet for additional requests.	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC: