



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: UGICAPOX

A BCCA "Compassionate Access Program" request form must be completed and approved prior to treatment

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(s) #:		
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 1.2 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/L, Creatinine Clearance greater than 50 mL/minute				
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 _____. Ondansetron 8 mg PO prior to treatment Dexamethasone 8 mg or 12 mg (circle one) PO prior to treatment <input type="checkbox"/> Other:				
<input type="checkbox"/> Calcium Gluconate 1000 mg and Magnesium Sulfate 1000 mg given together in 250 mL D5W IV over 20 minutes pre and post Oxaliplatin				
CHEMOTHERAPY: All lines to be primed with D5W <input type="checkbox"/> Repeat in three weeks				
Oxaliplatin 130 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ mg/m ² x BSA = _____ mg IV in 250 to 500 mL D5W over 2 hours				
Capecitabine 1000 mg/m² or _____ x BSA x (_____ %) = _____ mg PO bid with food x 14 days <i>(Round to nearest 150 mg)</i>				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____ <input type="checkbox"/> Return in six weeks for Doctor and Cycle _____ & _____. Book chemo x 2 cycles <input type="checkbox"/> Last Cycle. Return in _____ week(s)				
CBC & Diff, Platelets, Creatinine, Bili, AST, Alk Phos prior to each cycle <input type="checkbox"/> INR weekly <input type="checkbox"/> INR prior to each cycle <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:	