



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: GIENAFUPRT

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 24 hours ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L, and Creatinine Clearance greater than or equal to 60 mL/minute Dose modification for: <input type="checkbox"/> 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 Cisplatin Dexamethasone 8 mg or 12 mg (circle one) PO prior to Cisplatin <input type="checkbox"/> Other: _____		
CHEMOTHERAPY: Cisplatin 25 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 100 mL NS over 30 minutes daily x 3 or 4 days (circle one) Fluorouracil 1000 mg/m²/day x BSA = _____ mg/day for 4 days (total dose = _____ mg over 96 h) <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² /day x BSA = _____ mg/day for 4 days (total dose = _____ mg over 96h) IV in D5W to a total volume of 192 mL by continuous infusion at 2 mL/h via Baxter LV2 infusor		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in _____ weeks for Doctor and Cycle _____ x 1, 3 or 4 days (<i>circle one</i>) <input type="checkbox"/> Radiation Therapy to start Week 1 x 5 weeks with Chemo Weeks 1 & 5 <input type="checkbox"/> Last Cycle. Return in _____ week(s)		
CBC & Diff, Platelets, and Creatinine prior to each cycle If clinically indicated: <input type="checkbox"/> Total Protein <input type="checkbox"/> Alb <input type="checkbox"/> Bili <input type="checkbox"/> Alk Phos <input type="checkbox"/> GGT <input type="checkbox"/> ALT <input type="checkbox"/> Other tests: <input type="checkbox"/> Book for PICC assessment / insertion per Centre process <input type="checkbox"/> Book for IVAD insertion per Centre process <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC: