



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: GIENDO2

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 100 x 10⁹/L, Creatinine Clearance greater than 50 mL/min, Bilirubin less than 25 micromol/L				
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Renal Dysfunction <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 12 mg PO prior to treatment <input type="checkbox"/> Aprepitant 125 mg PO pre-chemotherapy on Day 1 and 80 mg PO post-chemotherapy once daily on Days 2 and 3				
CHEMOTHERAPY:				
Streptozocin 500 mg/m²/day x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____% = _____ mg/m ² x BSA = _____ mg IV daily in 100 mL NS over 15 minutes x 5 consecutive days (Days 1-5)				
Doxorubicin 50 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____% = _____ mg/m ² x BSA = _____ mg IV push on Day 1 and Day 22				
OR				
Fluorouracil 400 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____% = _____ mg/m ² x BSA = _____ mg IV push daily x 5 consecutive days (Days 1-5)				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in six weeks for Doctor and Cycle _____. Book chemo on Days 1-5 and Day 22				
<input type="checkbox"/> Last Cycle. Return in _____ week(s)				
CBC & Diff, Platelets prior to each treatment on Day 1 and 22 Creatinine prior to each treatment on Day 1				
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"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:		SIGNATURE:		
		UC:		