



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: UGIRAJCOX

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

**DOCTOR'S ORDERS**

Ht \_\_\_\_\_ cm Wt \_\_\_\_\_ kg BSA \_\_\_\_\_ m<sup>2</sup>

**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:

Delay treatment \_\_\_\_\_ week(s)

**CBC & Diff, Platelets** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to  $1.2 \times 10^9/L$ , Platelets greater than or equal to  $75 \times 10^9/L$ , Creatinine Clearance greater than 50 mL/minute**

Dose modification for:  **Hematology**  **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

**Other:** \_\_\_\_\_

**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  **Repeat in three weeks**

**Oxaliplatin 130 mg/m<sup>2</sup>** x BSA = \_\_\_\_\_ mg

Dose Modification: \_\_\_\_\_ mg/m<sup>2</sup> x BSA = \_\_\_\_\_ mg

IV in 250 to 500 mL D5W over 2 hours

**Capecitabine 1000 mg/m<sup>2</sup>** or \_\_\_\_\_ x BSA x ( \_\_\_\_\_ %) = \_\_\_\_\_ mg PO bid with food x 14 days  
(Round to nearest 150 mg)

**RETURN APPOINTMENT ORDERS**

Return in **three** weeks for Doctor and Cycle \_\_\_\_\_

Return in **six** weeks for Doctor and Cycle \_\_\_\_\_ & \_\_\_\_\_. Book chemo x 2 cycles.

Last Cycle. Return in \_\_\_\_\_ week(s)

**CBC & Diff, Platelets, Creatinine, Bili, AST, Alk Phos** prior to each cycle

**INR** weekly  **INR** prior to each cycle

**Other tests:** \_\_\_\_\_

**Weekly Nursing Assessment**

**Consults:** \_\_\_\_\_

**See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: