BC CANCER
Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: BRAVABR

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:

☐ 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 1.5 x 10^9/L, Platelets greater than or equal to 100 x 10^9/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 ____________________________.

☐ **Other:**

****Have Hypersensitivity Reaction Tray and Protocol Available****

CHEMOTHERAPY:

PACLitaxel NAB (ABRAXANE) 260 mg/m^2 x BSA = ___________mg

☐ Dose Modification: ___________mg/m^2 x BSA = _________mg

IV over 30 minutes (in empty sterile PVC, non-PVC or non-DEHP bag and tubing; use tubing with **15** micron filter)

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _________

☐ Last Cycle. Return in ____________weeks.

CBC & Diff, Platelets prior to each cycle (Bilirubin, LFTs, Creatinine required prior to Cycle 1)

If clinically indicated: ☐ **Bilirubin** ☐ **Alk Phos** ☐ **ALT** ☐ **GGT**

☐ **Creatinine** ☐ **BUN**

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**