PROTOCOL CODE: BRAVNAV

DOCTOR’S ORDERS

Ht____________ cm  Wt___________ kg  BSA____________ m²

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 24 hours ANC greater than or equal to 1.5 × 10⁹/L, Platelets greater than or equal to 90 × 10⁹/L

Dose modification for:  ☐ Hematology  ☐ ECOG  ☐ Other Toxicity

Proceed with treatment based on blood work from ____________________________

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm ____________________________.

☐ Prochlorperazine 10 mg PO prior to treatment
☐ Metoclopramide 10 – 20 mg PO prior to treatment
☐ Hydrocortisone 100 mg IV in 50 mL NS over 20 minutes pre-Vinorelbine (for patients who have had previous phlebitis)
☐ Other:

CHEMOTHERAPY:

DAY 1 and 8

Vinorelbine 30 mg/m²/day or 25 mg/m²/day (circle one) x BSA =__________mg

☐ Dose Modification: ________% = ________ mg/m²/day x BSA = ________ mg

IV in 50 mL NS over 6 minutes on Day 1 and Day 8. Flush vein with 75 to 125 mL NS following infusion of Vinorelbine

OR

DOSE MODIFICATION REQUIRED ON DAY 8

Vinorelbine 30 mg/m²/day or 25 mg/m²/day (circle one) x BSA =__________mg

☐ Dose Modification: ________% = ________ mg/m²/day x BSA = ________ mg

IV in 50 mL NS over 6 minutes. Flush vein with 75 to 125 mL NS following infusion of Vinorelbine

RETURN APPOINTMENT ORDERS

☐ Return in three weeks for Doctor and Cycle____. Book chemo room Day 1 and Day 8
☐ Last Cycle. Return in ________ weeks.

CBC & Diff, platelets prior to each treatment

If clinically indicated:  ☐ Bilirubin
☐ Other tests:

☐ Consults:

☐ See general orders sheet for additional requests.

DOCTOR’S SIGNATURE:  SIGNATURE:

UC: