**PROTOCOL CODE: GIAJCAP**

**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
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**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, creatinine day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to** 1.5 x 10⁹/L, **Platelets greater than or equal to** 75 x 10⁹/L, **Creatinine Clearance greater than** 50 mL/min.

Dose modification for:  ☐ Hematology  ☐ Age/ECOG  ☐ Other Toxicity ____________________

Proceed with treatment based on blood work from ____________________

**CHEMOTHERAPY:**

capecitabine 1250 mg/m² or 1000 mg/m² *(circle one)* x BSA x ( _______%) = _________mg PO bid with food x 14 days

(Round dose to nearest 150 mg)

**RETURN APPOINTMENT ORDERS**

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

☐ Last Cycle. Return in _________ week(s)

**CBC & diff, platelets, creatinine** prior to each cycle

If clinically indicated:  ☐ BUN  ☐ Total Protein  ☐ Albumin  ☐ Bilirubin  ☐ Alk Phos  ☐ GGT  ☐ ALT  ☐ INR weekly  ☐ INR prior to each cycle

☐ Other tests:

☐ Weekly Nursing Assessment

☐ Consulti:

☐ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**