PROTOCOL CODE: GIAVCRT

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, creatinine** 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 75 x 10^9/L, and creatinine clearance greater than or equal to 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 _____.

TREATMENT – Concomitant with RT (dual modality):

capecitabine 825 mg/m^2 or _____ x BSA x (_____%) = _____ mg PO BID (refer to Capecitabine Suggested Tablet Combination Table for dose rounding). The second dose should be taken 10-12 hours after the first dose. To be dispensed in appropriate weekly intervals Monday to Friday, with Saturday, Sunday and statutory holidays off, beginning on the first day of Radiation Therapy and **ending on the last day of RT**.

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor assessment during RT

☐ Last Cycle. Return in _____ week(s)

CBC & Diff, creatinine weekly during radiation therapy

If clinically indicated during radiation therapy:

☐ **total bilirubin** weekly ☐ **ALT** weekly

If clinically indicated prior to return appointment:

☐ **CEA** ☐ **CA19-9** ☐ **ECG**

☐ **total bilirubin** ☐ **ALT** ☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT**

☐ **sodium** ☐ **potassium**

☐ **INR** weekly ☐ **INR** prior to return appointment

☐ **Other tests:**

☐ **Weekly nursing assessment for (specify reason): _____**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: