**PROTOCOL CODE: GIAVCRT**

### 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, 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 ____________________________.

### CHEMOTHERAPY – Concomitant with RT (dual modality):

capcitabine 825 mg/m² or _______ x BSA x ( _____ %) = ______ mg PO bid with food; the second dose should be taken 10-12 hours after the first dose. (Total daily dose = 1650 mg/m²) 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**.

(Round to the nearest 150 mg).

### RETURN APPOINTMENT ORDERS

- [ ] Return in ________ weeks for Doctor assessment during RT
- [ ] Last Cycle. Return in _________ week(s)

CBC & diff, platelets, creatinine weekly during radiation therapy

- [ ] INR weekly
- [ ] Other tests:
- [ ] Weekly Nursing Assessment for (specify reason): __________________________

See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**