PROTOCOL CODE: GIAVFL

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(s) #:

Date of Previous Cycle:

☐ Delay treatment ______ week(s)

☐ CBC & Diff, Platelets, Bili, ALT, Alk Phos day of treatment

May proceed with doses as written if within 72 hours ANC greater than or equal to $1 \times 10^9$/L, Platelets greater than or equal to $75 \times 10^9$/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 __________________________.

CHEMOTHERAPY: ☐ Repeat in two weeks

leucovorin 400 mg/m² x BSA = _______ mg

IV in 250 mL D5W over 1 hour 30 minutes

OR

leucovorin 20 mg/m² x BSA = _______ mg

IV push

fluorouracil 400 mg/m² x BSA = _______ mg

☐ Dose Modification: _______ mg/m² x BSA = _______ mg

IV push THEN

fluorouracil 2400 mg/m² x BSA = _______ mg**

☐ Dose Modification: _______ mg/m² x BSA = _______ mg**

IV over 46 hours in D5W to a total volume of 230 mL by continuous infusion at 5 mL/h via Baxter LV5 INFUSOR

** For 3000 to 5500 mg dose, select INFUSOR per dose range below (doses outside dose banding range are prepared as ordered):

<table>
<thead>
<tr>
<th>Dose Banding Range</th>
<th>Dose Band INFUSOR (mg)</th>
<th>Pharmacist Initial and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3000 mg</td>
<td>Pharmacy to mix specific dose</td>
<td></td>
</tr>
<tr>
<td>3000 to 3400 mg</td>
<td>3200 mg</td>
<td></td>
</tr>
<tr>
<td>3401 to 3800 mg</td>
<td>3600 mg</td>
<td></td>
</tr>
<tr>
<td>3801 to 4200 mg</td>
<td>4000 mg</td>
<td></td>
</tr>
<tr>
<td>4201 to 4600 mg</td>
<td>4400 mg</td>
<td></td>
</tr>
<tr>
<td>4601 to 5000 mg</td>
<td>4800 mg</td>
<td></td>
</tr>
<tr>
<td>5001 to 5500 mg</td>
<td>5250 mg</td>
<td></td>
</tr>
<tr>
<td>Greater than 5500 mg</td>
<td>Pharmacy to mix specific dose</td>
<td></td>
</tr>
</tbody>
</table>

DOCTOR’S SIGNATURE: SIGNATURE: UC:
<table>
<thead>
<tr>
<th>DATE:</th>
</tr>
</thead>
</table>

**RETURN APPOINTMENT ORDERS**

- [ ] Return in **two** weeks for Doctor and Cycle ______
- [ ] Return in **four** weeks for Doctor and Cycle _____ & ______. Book chemo x 2 cycles.
- [ ] Return in **six** weeks for Doctor and Cycles ____, ____ & ____. Book chemo x 3 cycles.
- [ ] Last Cycle. Return in ______ week(s).

**CBC & Diff, Platelets** prior to each treatment

- [ ] Bilirubin, ALT, Alk Phos, Creatinine prior to each doctor’s visit
- [ ] INR weekly  [ ] INR prior to each cycle
- [ ] CEA  [ ] CA 19-9

- [ ] Other tests:
  - [ ] Book for PICC assessment / insertion per Centre process
  - [ ] Book for IVAD insertion per Centre process
  - [ ] Weekly Nursing Assessment for (specify concern): ____________
  - [ ] Consults:
  - [ ] See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**