



Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: GIAVTZCAP

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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:					
<input type="checkbox"/> Delay treatment _____ week(s)					
<input type="checkbox"/> CBC & Diff day of treatment					
May proceed with doses as written if within 24 hours ANC greater than or equal to $1.5 \times 10^9/L$, platelets greater than or equal to $75 \times 10^9/L$, creatinine clearance greater than 50 mL/min , bilirubin less than 25 micromol/L , and ALT less than or equal to 2.5 x ULN					
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity: _____					
Proceed with treatment based on blood work from _____					
TREATMENT:					
capecitabine 750 mg/m² x BSA x (_____ %) = _____ mg PO BID Days 1 to 14 (refer to <u>Capecitabine Suggested Tablet Combination Table</u> for dose rounding)					
temozolomide 200 mg/m² or _____ mg/m ² x BSA x (_____ %) = _____ mg PO daily Days 10 to 14 (refer to <u>Temozolomide Suggested Capsule Combination Table</u> for dose rounding)					
RETURN APPOINTMENT ORDERS					
<input type="checkbox"/> Return in four weeks for Doctor and Cycle _____					
<input type="checkbox"/> Last Cycle. Return in _____ week(s).					
CBC & Diff, creatinine, total bilirubin, ALT prior to each cycle					
If clinically indicated:					
<input type="checkbox"/> 24-hour urine 5-HIAA <input type="checkbox"/> ECG					
<input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> albumin <input type="checkbox"/> GGT <input type="checkbox"/> sodium <input type="checkbox"/> potassium					
<input type="checkbox"/> random glucose					
<input type="checkbox"/> INR weekly <input type="checkbox"/> INR prior to each cycle					
<input type="checkbox"/> Other tests:					
<input type="checkbox"/> Weekly nursing assessment					
<input type="checkbox"/> Consults:					
<input type="checkbox"/> See general orders sheet for additional requests.					
DOCTOR'S SIGNATURE:			SIGNATURE:		
			UC:		