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: GIBAJCAP

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, creatinine clearance greater than 50 mL/min.**

Dose modification for: ☐ **Hematology** ☐ **Age/ECOG** ☐ **Other Toxicity** _____

Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____

CHEMOTHERAPY: ☐ **Repeat in three weeks**

capecitabine 1000 mg/m^2 or _____ x BSA x (_____%) = _____mg PO BID x 14 days

(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

RETURN APPOINTMENT ORDERS

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

☐ Return in **six** weeks for Doctor and Cycle _____ & _____. Book chemo x 2 cycles

☐ Last Cycle. Return in _____ week(s)

CBC & Diff, creatinine, total bilirubin, ALT prior to each cycle

If clinically indicated:

☐ **ECG** ☐ **CEA** ☐ **CA19-9**

☐ **alkalinbe phosphatase** ☐ **GGT** ☐ **albumin** ☐ **sodium**

☐ **potassium** ☐ **random glucose**

☐ **INR** weekly ☐ **INR** prior to each cycle

☐ **Other tests:**

☐ **Weekly nursing assessment**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: