



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: GICAPIRI

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 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, Creatinine Clearance greater than 50 mL/min**

Dose modification for: **Hematology** **Age greater than or equal to 65** **Other Toxicity** _____

Proceed with treatment based on blood work from _____

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

ondansetron 8 mg PO prior to treatment

dexamethasone 8 mg or 12 mg (circle one) PO prior to treatment

Prophylactic atropine 0.3 mg SC

Other:

CHEMOTHERAPY: **Repeat in three weeks**

irinotecan 200 mg/m² x BSA = _____ mg

Dose Modification: _____ mg/m² x BSA = _____ mg

IV in 500 mL D5W over 1 hour 30 minutes

capecitabine 800 mg/m² or _____ x BSA X (_____ %) = _____ mg PO BID x 14 days

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

Counsel patient to obtain supply of loperamide and take 4 mg PO at first onset of diarrhea and then 2 mg PO q 2 h until diarrhea free x 12 hours (may take 4 mg PO q 4 h during the night).

atropine 0.3 to 0.6 mg SC prn repeat up to 1.2 mg for early diarrhea, abdominal cramps, rhinitis, lacrimation, diaphoresis or flushing.

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, Platelets, Creatinine, Bili, ALT, Alk Phos prior to each cycle

INR weekly **INR** prior to each cycle

CEA **CA19-9**

Other tests:

Weekly Nursing Assessment

Consults:

See general orders sheet for additional requests.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: