



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: GICAPOX

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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(s) #:
Date of Previous Cycle: _____				
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, Platelets day of treatment May proceed with doses as written if within 96 hours ANC greater than or equal to 1.2 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/L, Creatinine Clearance greater than 50 mL/minute				
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> 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 NO ice chips <input type="checkbox"/> Other: _____				
CHEMOTHERAPY: All lines to be primed with D5W <input type="checkbox"/> Repeat in three weeks oxaliplatin 130 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ mg/m ² x BSA = _____ mg IV in 250 to 500 mL D5W over 2 hours <input type="checkbox"/> RN to administer 250 to 1000 mL D5W concurrently with oxaliplatin infusion, titrated to reduce phlebitis discomfort for patient capecitabine 1000 mg/m² or _____ x BSA x (_____ %) = _____ mg PO BID x 14 days (refer to Capecitabine Suggested Tablet Combination Table for dose rounding)				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____ <input type="checkbox"/> Return in six weeks for Doctor and Cycle _____ & _____. Book chemo x 2 cycles <input type="checkbox"/> Last Cycle. Return in _____ week(s)				
CBC & Diff, Platelets, Creatinine, Bilirubin, ALT, Alk Phos, Sodium, Potassium, Magnesium, Calcium prior to each cycle <input type="checkbox"/> INR weekly <input type="checkbox"/> INR prior to each cycle <input type="checkbox"/> ECG <input type="checkbox"/> CEA <input type="checkbox"/> CA 19-9 <input type="checkbox"/> Other tests: <input type="checkbox"/> Weekly Nursing Assessment for (specify concern): _____ <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:			SIGNATURE:	
			UC:	