PROTOCOL CODE: GICART

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 24 hours **ANC greater than or equal to 1.5 x 10^9/L, platelets greater than or equal to 100 x 10^9/L for mitomycin and greater than or equal to 75 x 10^9/L for capecitabine, creatinine clearance greater than 50 mL/min.**

Dose modification for: ☐ **Hematology** ☐ **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 mitomycin

dexamethasone 8 mg PO prior to mitomycin

☐ **Other:**

TREATMENT: Begins on **Day 1** of each radiotherapy course

mitomycin 10 mg/m^2 x BSA x (_____%) = _____mg (Maximum dose = 20 mg)

IV push on **Day 1, Week 1 and**

☐ **mitomycin 10 mg/m^2** x BSA x (_____%) = _____mg (Maximum dose = 20 mg)

IV push on **Day 29, Week 5 (optional)**

capecitabine 825 mg/m^2 x BSA x (_____%) = _____mg PO BID (refer to Capecitabine Suggested Tablet Combination Table for dose rounding). The second dose should be taken 10-12 hours after the first dose. To be dispensed in appropriate weekly intervals Monday to Friday, with Saturday, Sunday and statutory holidays off, beginning on the first day of Radiation Therapy and **ending on the last day of RT**

RETURN APPOINTMENT ORDERS

☐ Radiation Therapy to start Week 1 x 5½ weeks
☐ Return in _____ weeks for Doctor assessment during RT
☐ Return in _____ weeks for Doctor and _____ week for PO capecitabine
☐ Last Cycle. Return in _____ week(s)

CBC & Diff, creatinine weekly

If clinically indicated: ☐ **total bilirubin** weekly ☐ **ALT** weekly

If clinically indicated:
☐ **CEA** ☐ **CA19-9** ☐ **ECG**
☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT**
☐ **sodium** ☐ **potassium**
☐ **INR** weekly ☐ **INR** prior to return appointment
☐ **Other tests:**
☐ **Weekly nursing assessment**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

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