



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: 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:				
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & diff, platelets, creatinine day of treatment May proceed with doses as written if within 24 hours ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L for mitomycin and greater than or equal to 75 x 10⁹/L for capecitabine, Creatinine Clearance greater than 50 mL/min. 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 mitomycin				
dexamethasone 8 mg PO prior to mitomycin				
<input type="checkbox"/> Other:				
CHEMOTHERAPY: Chemotherapy 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				
<input type="checkbox"/> 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 <u>Capecitabine Suggested Tablet Combination Table</u> 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				
<input type="checkbox"/> Radiation Therapy to start Week 1 x 5½ weeks <input type="checkbox"/> Return in _____ weeks for Doctor assessment during RT <input type="checkbox"/> Return in _____ weeks for Doctor and _____ week for PO capecitabine <input type="checkbox"/> Last Cycle. Return in _____ week(s)				
CBC & diff, platelets, creatinine, weekly during treatment CBC & diff, platelets, creatinine, weekly for 2 weeks after chemoradiation <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: