**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
</tr>
</thead>
</table>

**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, 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 100 x 10⁹/L, Creatinine Clearance greater than or equal to 60 mL/min.**

**Dose modification for:**

- [ ] Hematology
- [ ] Other Toxicity

- [ ] Proceed with treatment based on blood work from ________________________

**PREMEDICATIONS:**

- [ ] ondansetron 8 mg PO prior to chemotherapy
- [ ] dexamethasone 8 mg PO prior to chemotherapy
- [ ] metoclopramide 10-20 mg PO prn prior to chemotherapy
- [ ] prochlorperazine 10 mg PO prn prior to chemotherapy
- [ ] Other:

- [ ] PREHYDRATION: 1000 mL NS over 1 hr prior to CISplatin

**CHEMOTHERAPY:** Chemotherapy begins on **Day 1** of each radiotherapy course

- [ ] CISplatin 60 mg/m² x BSA = ______ mg

- [ ] Dose Modification: ______ % = ______ mg/m² x BSA = ______ mg

- [ ] IV in 500 mL NS with 20 mEq potassium chloride, 1 g magnesium sulfate, 30 g mannitol over 1 hour on **Day 1, Weeks 1 and 5.**

- [ ] capecitabine 825 mg/m² x BSA x (_____%) = ______ mg PO bid with food. The second dose should be taken 10-12 hours after the first dose. (Total daily dose = 1650 mg/m²) 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 **four** weeks for Doctor and book chemo **Day 1, Week 5**
- [ ] 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, platelets, creatinine, electrolytes** weekly prior to treatment

- [ ] INR weekly
- [ ] Other tests:
  - [ ] Weekly Nursing Assessment
  - [ ] Consults:
  - [ ] See general orders sheet for additional requests.

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**

---

BC Cancer Agency Provincial Preprinted Order **GICPART**

Created: 1 Feb 2010  Revised: 1 Oct 2016