PROTOCOL CODE: GICPART

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, platelets, 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 100 x 10^9/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: Patient to take own supply. RN/Pharmacist to confirm _____.
ondansetron 8 mg PO prior to CISplatin
dexamethasone 8 mg PO prior to CISplatin
☐ **Other:**

PREHYDRATION: 1000 mL NS over 1 hr prior to CISplatin

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

CISplatin 60 mg/m^2 x BSA = _____mg
☐ Dose Modification: _____% = _____ mg/m^2 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/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 **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, sodium, potassium weekly prior to treatment
☐ **INR** weekly ☐ **INR** prior to each cycle
☐ **Other tests:**
☐ **Weekly Nursing Assessment**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:
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